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Staff Experiences of Compassion on Acute Inpatient Wards

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Portfolio submitted in fulfilment of the requirements for the Professional Doctorate in Psychology (DPsych)

City University of London

Department of Psychology

School of Arts and Social Sciences

January 2021

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Summary of Treatment Recommendations Based on Research Findings

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Acknowledgements

To my research supervisor, Trudi, I would like to a say a sincere thank you for your support and encouragement and for getting me to the finish line.

To all of the nursing staff who agreed to share their experiences with me, and for your time. I hope I have done some justice toward conveying your experiences of compassion.

To my husband, you have been on this journey with me which started when we met on holiday in Kenya. This wouldn't have been possible without your love, support, and encouragement. It has been difficult at times, and I thank you, and I love you.

To my mum and brother. Thank you for everything that I can't put into words. I love you both dearly.

There are too many people to thank for their encouragement and for the personal and professional opportunities they gave. I would like to acknowledge a few. Dr. Claire Williams, Caroline Oaks, and Pierre John Cousin. Thank you.

To Tiril Garner, a special thank you for your help behind the scenes in getting me to the finish line. I would also like to thank the Department of Psychology at City, University of London for their support.

I dedicate this portfolio to you all.

Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Preface

This thesis features aspects of the theory and practice within the discipline of Counselling Psychology, with a focus on 'interpersonal relationships' which I believe connects the entire portfolio. It represents my engagement with the two contrasting epistemological positions within Counselling Psychology: the subjective-reflective-practitioner position and the empirical-scientist position. The following pieces of clinical, research, and academic work of which will be outlined, attempt to demonstrate a prioritization of the phenomenological experience of an individual whilst critically engaging with the medical model, and well as my own reflective stance. Included is the evolution and development of the portfolio, the themes permeating between them, as well as issues related to the theory and practice of Counselling Psychology, that I have encountered, which have consolidated my identity as Counselling Psychologist.

In SECTION ONE, I present a reflective case study of my clinical work which forms part of the practitioner component of the doctoral portfolio. This section narrates my work with [redacted]. Our work concentrated on his low mood, his inability to keep track of time, and his negative appraisals of shame and stigma which he experienced in relation to mental illness. My chosen treatment modality was to utilise transdiagnostic Cognitive Behavioural Therapy techniques, which had a growing evidence base for treating the symptoms of PPD, as well as incorporating third wave Cognitive Behavioural Therapy techniques, such as Acceptance and Commitment Therapy in a personalised formulation driven approach. At the forefront of this work was to use the therapeutic relationship to integrate Tom's experience of his diagnosis, and his early childhood neglect into less painful narratives, and thus shifting his experience temporally, and toward behaviours more in line with his personal values and goals – a key component in his recovery. The therapeutic journey was not without its difficulties, however with a strong commitment to this interpersonal and relational aspect of therapy, and through fostering a relationship that was non-hierarchical, de-stigmatizing, and one which tried to avoid re-enforcing Tom's negative beliefs about himself and in his relation to the world, we were able to make some therapeutic

gains. The case study illuminates my personal reflections about the work as well as learnings from the case a practitioner.

In SECTION TWO, I present my doctoral research, which forms part of the scientist-practitioner aspect of the portfolio and is the main component in which I explore the lived experiences of how staff nurses working on acute inpatient wards experience compassion. I have chosen to use an Interpretive Phenomenological Analysis (IPA) methodology in order to access these experiences from seven staff nurses. The findings illuminated that staff nurses' experiences of compassion were embedded within their interpersonal relationships with their patients as well as with their colleagues. Understandings about the meaning of compassion, as well as motivational aspects to facilitate compassion, or inhibit compassion appeared relationally. It appeared that staff nurses experienced an oscillation between the two positions, which sometimes led to a movement *towards* patients to respond compassionately to them, or as a movement *leaning* away from patients when they were unable to respond compassionately to them. This supports the relevance of interpersonal relationships in this setting as a way to understand the subjective and nuanced experiences that are involved in compassionate responding. These findings were interpreted through the construct of Psychological Flexibility which is an Acceptance and Commitment Therapy third wave Cognitive Behavioural Therapy intervention, which is increasingly gaining traction in hybrid models for the Compassionate Mind Approach. Particular attention was made in the treatment recommendations for this study to incorporate third wave approaches that are underpinned by a phenomenological approach tailored to open up avenues which can pay more attention to individual difficulties and the subjective experiences of staff nurses in this setting, to inform counselling psychology practice with regards to compassionate responding.

In SECTION THREE, I present my publishable paper, with the aim of it being published in the *Journal of Qualitative Health Research* (Impact factor 2.623). It was chosen so that the findings can be disseminated to an appropriate audience as the journal calls for articles that 'further the development and understandings of qualitative research methods in health care settings', the paper concentrates on the processes of one of the sub themes found of nurses *leaning away* from patients (as an inhibitor of compassion). Counselling Psychologists are actively engaged in evidence-based practises and welcomes incorporating newer knowledge into existing therapeutic approaches. The treatment recommendations that emerged from the findings

include '3rd wave' CBT approaches which focuses more on thought processes rather than thought content, such as Acceptance and Commitment Therapy and Mindfulness, as well as Compassionate Mind Techniques, where there is more of a focus on the therapeutic relationship offering Counselling Psychologists and other practitioners avenues to work pluralistically focusing on specific individual needs.

Development of Thesis

My initial interest in compassion and the ideas of the compassionate mind approach were sparked during some of my lectures in the second year of my training when a guest lecturer came to present the theory and practice of the compassionate mind approach, as well as her case studies of having used the approach with her clients. In the final year of my training, whilst I was facilitating compassion focused therapy groups for patients in an acute mental health setting; I noticed two things whilst preparing for and delivering these groups on the wards, one was that nursing staff had not been exposed to any of the ideas from the compassionate mind framework, and secondly, even though the inpatients who had attended the group were acutely unwell, on medication, and at different stages in their recovery, they benefited from the psychoeducation component of the compassionate mind approach that teaches us that our brains are rooted in evolutionary systems that may not serve us anymore. They learnt that compassion could negate and calm us when we are feeling threatened or alarmed. It seemed disjointed that on the ward these frameworks were being taught in inpatient groups but did not feature in any staff training at the time, nor was there any awareness within the wider system about the topics being run for inpatient groups by the psychology team. Having worked as part of the team I could see first-hand the challenges that the nurses faced in their day to day working lives, and I wondered if compassion could not only benefit them but also potentially create a ward-based environment where compassionate mind approaches or techniques could be utilised. So, I decided to focus my research on understanding how nursing staff experience compassion in their daily working lives, and to understand if there was any utility in training nurses in compassionate mind techniques. At the time of the study, there wasn't the baseline understanding of how nursing staff experience compassion, so I decided to do a qualitative research study in order to explore the detailed nuances of what nurses understand by compassion.

Designing and implementing this study has allowed me to develop critical research skills; to better understand philosophical and epistemological positions underscoring the research process; and to understand the myriad of ways in which knowledge can be understood and generated. The process of research has also helped me to align my identity as a counselling psychologist to value the phenomenological experience of and individual and at the same time be able to hold a more empiricist view. I hope that I have been able to do justice and accurately represent the experiences of the staff nurses that I have interviewed.

Themes Permeating Throughout the Portfolio

As mentioned above, each section of the portfolio is linked by an overarching theme pertaining to 'interpersonal relationships', via subjective and intersubjective experiencing, between us, and that of others. All of the individuals included within this portfolio imparted the need to understand, and to be understood, by others in their social environments. In my case study, with Tom, although the model of choice was Cognitive Behavioural Therapy (CBT), in which the therapeutic relationship has not historically been prioritised, although continually changing, has always been at the centre of Counselling Psychology practice. Here the therapeutic relationship was a way of understanding Tom's wider relationships and how he viewed himself through this lens, and its relationship to his subsequent psychological difficulties. This stresses the importance for Counselling Psychologists who practice CBT to have more of a relational focus in their work. Additionally, the findings from the doctoral research also pertained to 'interpersonal relationships' as a unifying concept that linked all of the participants' experiencing and understanding of compassion. It was the relationship between nurse -nurse; nurse-patient; and between nurse -researcher, via participation in the hermeneutic circle, that it was possible to identify some of the process issues involved that featured in facilitating and inhibiting compassion in inpatient ward-based environments, of which can inform counselling psychology practice.

Counselling Psychologists seek employment in a variety of different settings and are increasing being employed by the NHS where the environment is influenced by the dominant medical model – of which is more akin to CBT. For Counselling Psychologists who adhere to phenomenological philosophies that underpin therapeutic work; catered towards the idiosyncratic experiences of an individual and their difficulties, it is important to harness such

relational processes when working with CBT and to find flexible and creative ways of doing so. For example, using understandings of how transference or how attachment theories can manifest itself within the therapeutic relationship, phenomenologically, can open up multiple avenues of enquiry to support the interventions from CBT models, that can aid to empower individuals and reduce psychological distress. This skilful integration of using evidence-based, multimodal, as well as the adoption of a reflective practitioner stance, is at the heart of counselling psychology practice – and is essential for us to contribute to research knowledge that incorporates and prioritises phenomenological understandings of experience that meet the needs of clients.

The Theory and Practice of Counselling Psychology

The process of this research has helped me to clarify my position within the discipline both as a practitioner and a researcher and has enabled me to feel confident in holding this dual identity. The development of thesis has highlighted 'real -world' challenges faced by professionals in the field. The pluralistic stance adopted by Counselling Psychologists, which acknowledges the multiple truths, and multiple perspectives of the world in which we live and work, poses dilemmas of how best to position oneself when engaging with dominant discourses for psychological distress such as diagnostic categories, psychological evaluation via prescribed guidelines, and standardised treatment interventions, and whilst reconciling these elements with our humanistic values and attempting to bridge this divide. The development of the clinical and research work contained within this portfolio has highlighted that it is indeed possible to retain the unique perspectives of our identity prioritising subjective and intersubjective experiences of individuals and their self-actualising potential, whilst offering counter narratives to the medical model. I have attempted to do this using the therapeutic relationship operating in CBT as a way of understanding Tom's difficulties, and similarly through my choice of phenomenological enquiry to ensure an in-depth and holistic understanding of human experiences in the context acute inpatient settings, not historically the forte for Counselling Psychologists.

Throughout my training I have had the opportunity of working with clients using a range of therapeutic modalities such as Person-Centred, Psychodynamic, and Cognitive Behavioural Theories, and have found it more relevant in real-world scenarios to skilfully integrate these

evidence-based approaches rather than using a singular approach. Specifically, Compassionate Mind (CM) frameworks and techniques resonated with me and made intuitive sense, it's theoretical underpinnings and techniques proved to be a unifying concept that spanned across the various learnings of my training. For example, CM frameworks include perspectives from evolutionary, developmental, neurobiological and well as newer developments in the field of neuroplasticity, which offer more holistic understandings of human distress of which I aim to adopt as foundational underpinnings in my future practice.

The phenomenological enquiry used in this study was designed to be contextually responsive to the here and now of the inpatient environment, where there has been a top-down policy perspective to increase compassionate practises to enhance patient care. One could argue that this is somewhat prescribed; however, it is hoped that engagement in this setting from a counselling psychology perspective that focuses on staff, of which the research has often favoured patients, could in some small way open up further avenues of knowledge making the implicit explicit, that has the potential to take into account the wider contemporary issues facing psychology at the moment such as discrimination, health inequalities, socio-economic, and the political discourses that affect the wider system for staff and patients alike.

The process of compiling this doctoral portfolio has been inspiring and a life-changing exercise for me. I would say that it has allowed me to self-actualise both as a scientist and practitioner and has clarified my position privileging phenomenological human experiences.

SECTION ONE

A Case Study Using CBT

DPsych, City University

Pem, Selene

Case Study

REDACTED

SECTION TWO

DOCTORAL RESEARCH

Staff experiences of Compassion on Acute Inpatient Wards

Selene Pem

Supervised by Dr Trudi Edginton

Abstract

There has been a growing body of research focusing on the efficacy of the compassionate mind approach and its integration into mental health services. However, there has been limited research exploring its applicability for inpatient service users, and less so for staff nurses working in this area of mental health. This study presents the findings from a larger qualitative study that explored staff nurses' experiences of compassion in an acute inpatient setting in order to get a baseline understanding of how they experience compassion in their workplace. Data were collected using semi-structured interviews with seven staff nurses who were currently in employment and analysed using Interpretive Phenomenological Analysis (IPA). The findings yielded two main themes comprising of 'Perspectives of Compassion' and 'The Conflict Within', and suggested that staff nurses oscillated in what, compassion is in general, what they perceive it to be, and how they experience it in their work. Nurse participants appeared to have a desire to engage in care and compassion, towards patients, as they understand it; but that this desired flow of compassion is modulated against the backdrop of when to engage, disengage and when to compassionately come back. The complexity of their experience appeared to be influenced by individual, professional, interpersonal, and psychological factors within the context of an acute inpatient ward. The results were contextualised using theoretical frameworks from the Compassion Mind Approach and Psychological Flexibility. The findings could add to the evidence base underpinning staff training programmes and shed light on how compassion can be integrated in the inpatient system as a whole.

Keywords Compassion; Nursing; Inpatient wards; Acute care; Interpretative phenological analysis; Psychological flexibility; Cognitive behavioural therapy

CHAPTER 1 – INTRODUCTION

In order to foreground the present study, I will draw the reader's attention to the construct of burnout and its implications, as it has been the most widely researched phenomena of staff experiences in acute inpatient wards; and will review the relevant findings. I will then discuss the historic and current context of an acute inpatient setting, of which this study is situated, before proceeding to introduce how compassion is defined and understood. The evolutionary and main theoretical perspectives underpinning compassion will also be discussed. I will then review the small body of existing literature available on nursing staff experiences of compassion in this setting, as well as drawing on other studies within the wider healthcare literature that are deemed applicable. Consideration will also be given to the significance of nursing resilience in this area. The rationale of the study will then be explained as well as its significance to the field of Counselling Psychology.

Burnout

Overview of Burnout

Burnout has been included for the purposes of this review because its studies have spanned over the past 40 years across multiple disciplines; its measures have a high construct validity, and it can offer a lens into the negative experiences that can occur for staff working in acute inpatient settings. Initial understandings of burnout stemmed from qualitative and exploratory research into the experiences of healthcare workers (Freudenberber, 1975; Chemiss, 1980; Maslach. 1993). Both UK and international researchers have contributed to the development of theoretical models of burnout, as well as in developing robust measures that identify the causes and outcomes of burnout. Maslach & Leiter (2016) refer to burnout as an 'occupationally specific dysphoria' and places the individual experience of burnout firmly as a 'stress experience' within a specific social context and involving a person's concept of themselves, in relation to others.

The construct was initially developed from a social research and clinical psychology perspective. The former focused on relationships and illuminated aspects of individual experience such as: detached concern, dehumanisation in self-defence, and certain attributional

processes, and more specifically contributed to a better understanding of the motivational and emotional aspects occurring in relation to experiences of burnout (Freudenberger (1974) in Miller et al, 1995; Maslach, 2001; Maslach & Leiter, 2016). In the latter clinical psychology perspective, there was also a focus on the motivational and emotional aspects of burnout, but they were conceptualised as psychological disorders such a depression; with the relationship between burnout and mental illness still be a point of debate today (Maslach & Leiter, 2016). Subsequent work featured in the area of organisational psychology, where burnout was operationalised as a job stress, reflecting job attitudes and behaviours. A key difference from this perspective is that the main focus was on the organisational context and less so on the internal characteristics of stress (Maslach & Leiter, 2016).

In terms of context, burnout has received a lot of attention within the wider nursing literature, and mirrors the broader burnout literature in terms of cause and effect; however, surprisingly, more studies have focused on a community mental health setting than on acute inpatient settings; where nurses are exposed to unique stressors; deal with more severe mental health issues; are required to offer 24 hour care; and have more intense therapeutic or service relationships (Jenkins & Elliot, 2004; Peters, 2018, O'Connor et al, 2018).

Definition of Burnout

Burnout has been defined as a 'psychological syndrome emerging from a prolonged response to chronic and interpersonal stressors on the job' (Maslach & Leiter, 2016). An agreed consensus in the literature has revealed that it's a multifaceted construct and consists of three key dimensions: overwhelming exhaustion, feelings of cynicism (formerly coined depersonalisation) and detachment from the job, and a sense of ineffectiveness and accomplishment (Maslach, 1993; 1996; Maslach & Leiter, 2016). The emotional exhaustion element of burnout focuses on the internal stress dimension of burnout, and refers to feelings of being overextended, having a loss of energy, emotional depletion and fatigue (Maslach, 2001). There is current debate within the literature to reconceptualise burnout as exhaustion (Maslach & Leiter, 2016). The depersonalisation element of burnout focuses on the interpersonal aspects of burnout, it refers to a negative (or inappropriate comments or behaviours towards patients), cynical, or an attitudinal detachment, or withdrawal towards

others, or certain aspects of the job (Maslach, 2001; Maslach & Leiter, 2016). Lastly, the reduced personal accomplishment dimension of burnout focuses on self-evaluation, and refers to negative self-evaluations of oneself, feelings of incompetence, low morale, and a lack of achievement and efficiency at work, as well as feeling unable to cope (Maslach, 2001; Maslach & Leiter, 2016).

It is however stressed that compassion fatigue (CF), a related construct to burnout has been omitted from this review, despite its obvious terminology to the research question. I offer three arguments; CF is defined in the nursing profession as consisting of three steps; discomfort, stress and fatigue (Coetzee & Klopper, 2010). The first is that there is contention in the literature because instruments that measure CF don't measure compassion per say, so it's difficult to ascertain whether compassion is present (Duarte J, Pinto-Gouveia J, 2017). Secondly, of the three steps only discomfort and stress are deemed to be reversable aspects of CF, and once the last step of fatigue has been reached, CF is said to be irreversible due to a depletion of compassionate energy (Coetzee & Klopper, 2010). This irreversible aspect doesn't lend itself towards current thinking of the neuroplasticity of the brain structures; in that compassion and mindfulness can alter and create new neural pathways of the brain. Conceptual difficulties have also been highlighted with stress and personality factors being inversely related to age, with younger and less experienced staff, experiencing more compassion fatigue (n=90) (Sinclair et al, 2016) which is a paradox. Lastly, CF is associated with a specific decline in empathic ability, and as a reaction to intense prolonged patient contact, whereas compassion is an acknowledgement of the suffering combined with a desire to help. Burnout has a slower onset, regarded as a stress related reaction to a nurse working environment and is not just specifically to do with interpersonal contact, so more relevant to the context of in this study (Hanrahan et al, 2010)

Studies of Nursing Burnout. What so they show?

Within the wider nursing literature studies have shown that burnout is a concern. Even milder instances of burnout have been associated with increased mental health difficulties for staff (Ahola at al., 2005), as well as impairments in their somatic health and overall emotional well-being (Stalker & Harvey., 2002; Acker., 2010). A Finish based study (N=3,276) found that job-

related burnout was associated with a 3.3-fold increased risk of having a major depressive disorder, with the risk being three times more prevalent for men than women (Ahola et al., 2005; Morse et al., 2012). Another study across 28 mental health units found a correlation between high emotional exhaustion amongst psychiatric workers (N=510) with negative attitudinal behaviours towards patients on their wards, such as distancing and rejecting (Holmqvist & Jeanneau, 2006). Staff who experience burnout have also shown a reduced adherence to evidence-based practices, and a reduction in the quality and continuity of mental health care (Mancini et al, 2009; Boyer & Bond, 1999), which in turn has been linked to poorer outcomes for mental health patients (Gowdy, Carlson, & Rapp, 2003). In general, most of the studies in this field are cross-sectional or correlational in design, and there is an absence of larger longitudinal studies, so it is difficult to draw concrete conclusions about the direction of these relationships i.e., individual differences, situational and organisational factors are likely to be contributary variables to these results.

In terms of acute inpatient settings of which is the context for this study, Jenkins and Elliott (2004), in an interesting study, compared the levels of stressors and burnout experienced by qualified and unqualified nursing staff (N=93) working across 11 adult inpatient wards across 4 UK based hospitals in a similar geographical location (response rate 39%). They adopted a survey design and also examined the relationships between stressors and burnout for the sample as a whole. The impact of social support on burnout was also assessed, in addition to the stressor-burnout relationship (buffering). A convenience sample of nurses completed three measures: The Mental Health Professionals Stress Scale (MHPSS), with Cronbach's α = 0.94 for mental health nurses; The Maslach Burnout Inventory (MBI), with Cronbach's α = 0.90, 0.75, 0.76 (for emotional exhaustion, depersonalisation, and personal accomplishment respectively); and the House and Wells Social Support Scale with Cronbach's α values = 0.84. All chosen measures demonstrated a good internal validity. A lack of adequate staffing was identified as a main stressor for qualified staff, whereas dealing with physically threatening, or difficult or demanding patients were identified as being the main stressor for unqualified staff. Qualified nurses were also identified as scoring significantly higher than unqualified nurses on the workload subscale.

The same study also identified that half of the total sample of nurses were experiencing the emotional exhaustion dimension of burnout P=0.802, but the two groups did not differ significantly. Interestingly, and likely to be relevant to this current study, the findings suggest that there is a significant negative correlation between the support of co-workers and the MBI emotional exhaustion scores, i.e., higher support from co-workers is associated with lower levels of emotional exhaustion ($r = -0.32, P = 0.002$). This finding is consistent with other studies that have found that staff gravitate towards colleagues for work related difficulties as opposed to their superiors or external sources (Dallender *et al.* 1999). Surprisingly, the authors also found that there was what they called a reverse buffering effect in that, higher levels of support from co-workers did not buffer the effects of higher stressor scores and higher levels of depersonalisation, but not for staff citing lower levels of support. The authors postulated that this could be related to communication difficulties, in that supportive staff communications were occurring but in the direction of more practical concerns with less emphasis on individuals' emotions or appraisals of a situation. Although this study identifies particular areas of significance, and offers an appropriate choice of methodology, it is limited in its scope due to its cross-sectional design. It's hard to identify any causal links to the findings. Additionally, the choice of convenient sampling, although having its advantages in terms of yielding a high number of participants, it gives rise to a self-selection bias. The wider spectrum of nursing staff experiences is unable to be captured, i.e., participation rates in the study can reflect staff wanting to talk about their distressed feelings, or alternatively due to these issues unable to participate because of a limited capacity. Additionally, a disadvantage of survey studies such as this, is that it would have been difficult to capture any controversial all sensitive issues that could arise as a result of face-to-face interviews or focus groups.

The experience of burnout for nurses working in inpatient settings is extremely likely to be relevant when exploring staff experiences of compassion, as it may play a role in perceptions, inhibitors or facilitators of compassion, of which is the focus of this study.

Inpatient Settings

As burnout is a stress related reaction to ones working environment, it seems helpful to understand the context of an inpatient working environment in order to situate the current study. Acute psychiatric in-patient services provide crucial care to those suffering from severe mental health difficulties. Throughout the 1950s to 1970s, there was a growing awareness about the 'iatrogenic' nature for psychiatric inpatients within institutions, i.e., illness originating from the proposed remedy, which led to a change in the mental health discourse at the time and led to patients being viewed from a much more holistic perspective (Kings Fund, 2018). Stemming from this, deinstitutionalisation of the UK mental health services; a process shifting care away from larger institutions and towards smaller community mental health teams; and although originating as a benevolent endeavour, complicated the matter further; and despite recent improvements, has continued until the present day (Kings Fund, 2018; NHS Benchmarking Network, 2018).

Historically, mental health funding hasn't been on par with physical health, which poses significant constraints on service delivery in this area which has an ever-rising demand; however, the 2013 commitment of 'parity and esteem'; i.e., efforts to close this gap in terms of quality and equal status between physical and mental health was well received; however, concerns were raised five years later in the *NHS five-year forward view* about meeting these commitments due to resource stagnation (Kings Fund, 2018; NHS Benchmarking Network, 2018). However, in January 2019 recent government commitments, outlined by the revamped NHS long-term plan, pledged that mental health investment will increase by £2.3bn a year by 2023/24; it is unknown how much of this allocation will be signposted for acute inpatient services (Kings Fund, 2019).

The resultant situation of the last decade has culminated in bed numbers at a ratio of 19.2 Acute Adult beds per 100,000 of the population (age range 16-64), a bed occupancy of 94%, of which 37% are the result of forced sectioning (NHS Benchmarking Network, 2018). These precarious conditions have led to a change in the profile of an inpatient service user; with higher threshold levels of admission for severely ill patients i.e., 63% of all occupied beds are for psychosis (NHS Benchmarking Network, 2018).

To further complicate matters there are a variety presenting problems; uncertain or dual diagnosis, wrongful admission of sometimes forensic patients, co-morbid drug or alcohol use, current cognitive functioning, and risk level; as well as service issues such as briefer and unpredictable admission lengths, staffing shortages (as a result of high staff turnover and reliance on agency staff), and the lack of availability of trained staff (Kings Fund, 2018; Heriot-Maitland et al, 2014; Totman et al, 2011; Clark & Wilson, 2009; Kennedy-Williams, 2013). Poor standards of care have been highlighted by both patients and staff, as well as a movement away from the core psychological processes of care toward target driven cultures of efficiency and output (Care Quality Commission, 2017; Wood & Alsawy, 2016; Muijen, 2002; Norton, 2004). However, promisingly recent findings do suggest improvements with an 88% patient satisfaction score of a 'Family & Friends Test' in this setting (NHS Benchmarking Network, 2018).

Nurses and support workers comprise of 79% of the Adult Acute impatient workforce, with 28% of pay costs allocated for bank and agency staff (NHS Benchmarking Network, 2018). Concerns about the lack of compassion from nurses in acute inpatient settings has consistently been highlighted in the literature as well as in governmental reports (Francis Report, 2013; Parliamentary and Health Service Ombudsman, 2011; Care Quality Commission, 2011). The Mid Staffordshire NHS Foundation Trust Inquiry, (2010) in their report to improve the quality of care in inpatient settings stressed the importance of attending to patient experiences, of which nurses are seen as paramount, of which is reflected in the follow-up Francis Report, (2013) which in turn places blame on individual staff members for a lack of care and compassion, as well as citing organisational failures.

Incongruously, compassion has also been difficult to define *within* the context of nursing, and there has been no mention of a definition or what it entails in governmental recommendations advocating for an improvement in compassionate care (Francis Report, 2013; Cleary et al., 2015). What is clear, is that compassion has been cited by both patients and nurses as a core element of mental health care in acute inpatient settings, and mechanistically through compassionate mind frameworks, has also been increasingly incorporated into mental health recovery model for patients, giving testimony of its intrinsic value in mental health (DoH, 2008; Gumley et al, 2010; Gilbert, 2017). Spander & Stickley (2011), highlight that compassion

works ‘in and through relationships’ which are shaped within specific contexts. Therefore, for nurses, their experiences of compassion, will inevitably be shaped by their environment, as well as with their interactions with patients and peers. It seems helpful to explore how nurses understand and experience compassion within acute inpatient settings.

Compassion

Defining and Understanding Compassion

Compassion is defined in the Collins English Dictionary (2018) as ‘a feeling of distress and pity for the suffering or misfortune of another, often including the desire to alleviate it’. An understanding of compassion exists in various notions across all of the world’s major religions, and is considered a virtue (Stevens, et al 2018 p.4). Compassion is defined similarly in the literature: “a sensitivity to the distress of self and others with a commitment to try to do something about it and prevent it” (Cole & Gilbert, 2011). Gilbert (2009) similarly identifies compassion as comprising of key attributes one involving the psychology of engagement; such developing specific competencies such as ‘caring, sensitivity to distress, sympathy, distress tolerance, empathy, and non -judgment’, with the second involving the psychology of alleviation, such as skills training in ‘attention, imagery, reasoning, behaviour, sensory and feeling’.

The difficulty that arises is that vernacular of compassion hasn’t been fully delineated within the academic and psychological literature and has been conflated with comparable terms such as kindness, caring, tenderness, and pity (Dewar et al, 2011; Gotz et al, 2010, Sinclair, 2018, Shaver et al, 1987), and has also been identified with certain ‘capacities’ such as empathy, sympathy, forgiveness and warmth (Gilbert, 2005 p.1; Zulueta ,2013). There has also been much debate in the literature about whether compassion is a brief like state, or trait (Gotz et al, 2010); with it more recently being included within the taxonomy of emotion research (Ekman, 1992: Rydon-Grange, 2017).

It is important to differentiate compassion from empathy, which has been used interchangeably within the literature. Empathy, a related construct, and an antecedent to compassion, is conceptually distinct from it. It has differing characteristics. Empathy ensues a “feeling into”

the experiences of another; it has an emotional element; experiencing what someone is feeling (to a weaker degree), and a cognitive element; understanding what someone is feeling, with an ability to differentiate the self from other (Decety & Jackson, 2004), with and attempt to appropriately regulate oneself so that over-identification doesn't take place, which has been demonstrated to be counterproductive within healthcare (Eisenberg & Eggum, 2009; Gilbert, 2017). Compassion on the other hand is a "feeling with" the experiences of the other, it identifies with the emotional and cognitive element of empathy but differs in that attention is directed towards the alleviation of that suffering and a desire to help (Stevens, et al 2018 p.7). Additionally, Buddhist traditions which underpin compassionate mind theories also define compassion as a wish for another to be free from suffering (Dalai Lama, 2012). What is clear is that compassion is a complex multifaceted construct, with no clear consensus on an agreed understanding or definition. A recent review by Strauss et al. (2016) has attempted to consolidate the existing definitions of compassion within the academic literature and have put forward a more encapsulating definition and propose that compassion consists of five elements: recognising suffering, understanding the universality of human suffering, feeling for the person suffering, tolerating uncomfortable feelings, and motivation to act/activating to alleviate suffering. However, this study utilises Cole & Gilbert's (2011) definition of compassion in showing a "sensitivity to the distress of others with a commitment to try to do something about it and prevent it", which seems relevant for the purposes of this study. Dewar et al (2011) put forward that when valuing compassion through definition and measurement, that it's important not just to understand quantifiable aspects of compassion such as a smile or a touch, but to also those aspects of compassion that could be considered more valuable in the provision of mental health care such as delivering compassionate care towards patients. This is the premise of which this study is situated.

Self-Compassion

Self -compassion is defined as 'extending compassion toward oneself, with three key components: mindfulness, self -kindness, and a sense of common humanity (Neff, 2003). Conceptualisations of compassion have generally addressed the interconnectedness between human beings (Tirch et al., 2014), so therefore self-compassion, although relevant has not been a focus of this current study due to the study's focus on compassionate care *towards* patients.

Buddhist Tradition

Compassion is rooted in Buddhist philosophy, where compassion is separated into "Karuna" and "Anukampa", with the former reflecting an inner state of meditative compassion, and the latter adopting a benevolent prosocial motivation to act compassionately, in situ (Goodman et al, 2018). In Buddhist interpretations, compassion is not seen as an emotional response, but as growing understanding of our shared common humanity and our interconnectedness with the suffering of others and of its temporary nature (Salzberg, 2017; Strauss et al, 2016; Goodman et al, 2018). The Dalai Lama imparts that "genuine compassion must have both wisdom and loving kindness. That is to say, one must experience deep intimacy and empathy, with other sentient beings, this is loving kindness (pg. 44, In Strauss et al, 2016).

Evolutionary Perspectives of the Compassionate Mind

The following two sections look at the evolutionary perspectives of compassion and the interconnectedness between human beings, which is likely to be relevant for nursing staff interactions with patients in a ward-based environment. Gilbert's (2010a) seminal work on the compassionate mind (CM) framework has drawn on evolutionary theory to conceptualise compassion, and its potential role in promoting psychological well-being. He postulates that we have a social mind that evolved processing systems which are "signal sensitive' and respond to signal sensitive systems in the mind of others, and vice versa (Gilbert & Irons, 2005). They comprise of basic social motivational and functional emotional systems (Gilbert, 2014; Cozolino, 2007, 2008; Siegel, 2008). These systems help us with our social goals that are deemed necessary for survival, such as navigating specific functions, such as caregiving, care-eliciting, forming alliances, social rank, and seeking sexual collaborators (Gilbert, 2014, Laithwaite et al, 2009). Social Mentality Theory and Social Rank Theory are two noteworthy theories likely to be relevant for this current study.

Social Mentality Theory

Social mentalities or internal systems, reflect interplays between patterns of cognitions, affect, behaviours and motivations, between us, and that of others, generating a neurophysiological

signature (Gilbert, 2005. Pg. 15). These systems underpin our interpersonal relating strategies that aid us to seek out resources, respond to threats, and seek out safety and contentment within a relationship (Gilbert, 2014, Gumley et al, 2010). The sensitivity of this is delicate and co-dependent, i.e., exhibiting aggression, which could be demonstrated via subtle facial expressions, could lead to an activation of fear or submission in the processing system of another; or a sexual display could lead to the activation of sexual interest in the processing systems of another; and cries of distress in a child could activate help or care-giving processing systems in a parent; whilst reciprocally a parental display of emotional attunement and warmth could activate processing systems of calming, safety and attachment in a child (Gilbert & Irons, 2005. Pg. 264; Kogan et al, 2014). Therefore, caring and compassion can be viewed as a social mentality (Gilbert, 2017). Individual differences, our early attachments histories, and epigenetics, all contribute to determining whether we accurately emit and receive these social signals, and whether we fail or succeed in achieving our social goals. Social mentality theory may have particular relevance for nurses working in acute inpatient settings, where sensitive signalling processes to and from staff and patients may contribute to experiences of compassion.

Social Rank Theory

Social rank is the perceptions or comparisons one makes about themselves in relation to others. We may adopt subordinate hierarchal positions within a society if we perceive someone to be of a higher social rank to us, to minimise treat, and achieve social cohesion and acceptance. It is counterproductive for subordinates to initiate conflict with those of higher rank or seniority, as it is unlikely to be successful, and costly to the individual (Gilbert, 2000). Submissive behaviour can include increased tension and inhibition, backing down, as well as associated fears of being disliked or rejected (Gilbert & Allen, 1994). Social acceptance and belonging are desirable evolutionary goals, if we see ourselves at a lower social rank to others, we are unlikely to develop safeness and which may indicate a social threat and psychological distress (Gilbert, 2000b).

From these theories Gilbert developed his core model called the ‘Affect Regulation System’ (Depue & Morrone-Strupinsky, 2005; LeDoux, 1998; Panksepp, 1998). It posits that there are

three systems that interact for effective emotional regulation and well-being. The systems are the threat system, drive system, and soothing system (Gilbert, 2010). The latter two systems concern positive affect. The threat system is essentially our fear response, and causes an activation of our fight, flight or freeze mechanisms in response to internal or external threat. The first positive system, the drive system is concerned with motivation and achievement, and actively encourages us to strive towards our goals. The drive system relates to meeting our basic needs/instincts e.g., sex, food, water etc. The drive system can be stimulated when things go in our favour or squashed when we perceive that there is a threat. The drive system, however, does not offer an enduring positive affect (Gilbert, 2010). The soothing system is the third affect-regulation system, and it is this system that is targeted by the compassion focused approach. This soothing is a sense of safeness experienced when we don't experience threat or when our drive system is not activated. It encompasses feeling cared for *by others*, having the intention to care *for others*, and having affiliative orientations *toward the self* (Gilbert, 2014). This soothing compassion system, once established, is able to offer a long-lasting positive affect, thus illustrating its importance in effective emotional regulation.

Social Mentality Theory (SMT, Gilbert, 2009) explains how emotional regulation can be achieved through our social relationships. Processing with our social mind enables us to respond to threat, seek out resources, and to assess states of contentment/safeness within a relationship (Gilbert, 2014). The flow of all three systems ensures emotional well-being. When the threat system is overstimulated, as is often the case in people who have had problematic early developmental and attachment histories (Bowlby, 1969; Mikulincer, 2007), people can develop internal threats (e.g., shame, low self- esteem) and/or external threats (e.g., others as untrustworthy or dangerous). This can then lead to safety seeking behaviours, such as withdrawal and avoidance (Gilbert, 2007), and feelings of anger and anxiety (Gilbert, 2010).

Both the drive and soothing system usually mitigate the threat system. CFT targets the soothing system, with the aim of developing self-compassion. It is this system that is often underdeveloped in patients (Gilbert & Irons, 2005; Gilbert, 2009), as is often the case with sufferers on an acute ward.

Measuring Compassion

The value of compassion as a psychological approach is increasingly being recognised in the literature. Problems arise in the study, measurement, and evaluation of compassion formed interventions, owing to a lack of an agreed consensus for the construct, coupled with poor construct validity in the metrics currently being used (Strauss et al, 2016). There has been more focus on quantitative methodologies in the research than qualitative or observer measures, and there has been particular focus on self-reported aspects of compassion. It has also been noted that compassion from a culturally determined viewpoint has also been overlooked (Papadopoulos et al, 2017).

Strauss et al (2016) systematically identified and reviewed nine measures in the study of compassion, which included the: Compassion Love Scale (CLS; Sprecher & Fehr, 2005); Santa Clara Brief Compassion Scale (SCBCC; Hwang, Plante, & Lackey, 2008); The Compassion Scale (CS-M; Martins, Nicholas, Shaheen, Jones, & Norris, 2013); Self-Compassion Scale (SCS; Neff, 2003b); Self Compassion Scale; Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011); The Compassion Scale (CS-P; Pommier, 2010); Relational Compassion Scale (RCS; Hacker, 2008); Compassionate Care Assessment Tool (CCAT, Burnell & Agan, 2013); Schwartz Centre Compassion Care Scale (SCCS; Lown, Muncer, & Chadwick, 2015). The CCAT is particularly noteworthy as it was developed to measure compassionate qualities demonstrated by individual nurses, towards patients in an acute hospital setting. The scale is completed from a patient perspective and measures compassionate care on two dimensions; the importance of each item to them, and the degree to which the nurses demonstrated. The scale was developed from with the spiritual needs survey and the caring behaviours inventory, and an agreed consensus with hospital staff involved in implementing a compassionate care agenda in the NHS (Strauss et al, 2016). However, the authors conclude poor internal consistency for subscales across the nine measures (low quality ratings), insufficient evidence for factor structure, floor/ceiling effects, test-retest reliability, discriminant validity, and issues with interpretation. A qualitative study such as this can yield deeper and richer insights about experiences of compassion and the complexities of human experience, which some of these measures are unable to access.

Role of Attachment

Our attachment histories can have a profound effect on affiliative behaviour and in turn can influence compassionate responding (Tirch et al., 2014). Bowlby's (1969, 1973) attachment theory explains that humans developed innate evolutionary propensities and competencies to seek out being cared for and supported by others. This is relevant for human infants, who as a matter of survival are dependent on caregivers for prolonged periods of time. In terms of our psychosocial development, our ability to form bonds help us to develop our sense of self, who we are in the world, and how we respond to others. It is widely understood and supported in the literature that our early childhood relationships with our primary caregiver sets schemas or internal working models of relating in all future relationships, such as with peers or romantic partners (Ainsworth, 1973; Bowlby, 1988; Main et al., 1995; Allen & Land, 1999). These developed schemas are called attachment styles which include secure, anxious/preoccupied, dismissive/ avoidant, or fearful avoidant strategies (Bowlby, 1969; Ainsworth, Blehar, Waters, & Wall, 1978; Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987). If we receive "good enough", consistent, and reliable caring by our primary caregivers, who are attuned to our emotional needs, it's likely that we will develop a secure attachment style, experienced external safety, and experience others as a reliable and trustworthy (Winnicot, 1960; Bowlby, 1969; Mukulincer & Shaver, 2007, pg. 11-23). Alternatively, if we had unreliable, inconsistent, neglectful or abusive primary caregivers, we are likely to develop insecure attachment styles, become threat focused, and perceive others as untrustworthy (Ainsworth, Blehar, Waters, & Wall, 1978; Gilbert, 2014). Experiences of these early relationships have implications for our genetic, physiological, and psychological processes across the lifespan, and also implicated in mental health and well-being (Gilbert, 2005; Mukulincer & Shaver, 2007, pg. 11-23; Cozolino, 2013). Seeking proximity, and receiving care and affection in childhood, is implicated in being caring and compassionate in adulthood (Gillath, Shaver, & Mikulincer, 2005).

Physiology of Stress

Research has shown that stress influences brain states that undermine compassion (Gilbert, 2017 pg. 95). Stress is described and anything that affects the 'homoeostasis' of the body (Hans Siegal, 1956). We have evolved neurohormonal responses to stressors (whether real or

imagined) that is facilitated by coordinated responses between the hypothalamic pituitary gland (HPA) axis and sympathetic nervous system. This HPA axis is significant as research has shown that it's activation 'antithetical' to caring (Gilbert, 2017, pg.95). For example, blocking the HPA axis in mice promotes 'emotional contagion' in strangers (Gilbert, 2017, pg.96).

According to Selye (1956) biologically, three systems are involved in our stress responses that are adaptive, bidirectional, and influenced by our interpretation of the world. They include the central nervous system (CNS), operating in negative feedback loops; regulated by the endocrine and immune systems. Stress can be acute, episodic, or chronic and can be described as consisting of three stages: alarm, adaptation, and exhaustion or recovery. Acute stress is transient stress and can be associated with instances of anger, anxiety, disgust or irritability by way as an example, but it is quick and short lived. Episodic stress occurs when stressful situations occur consecutively, while chronic stress is characterised by periods of longer-term, exposures to stressors that persist and accumulate over time. Chronic stress may not be as heightened as acute stress but it's ongoing and accumulative nature can significantly impact physical and mental well-being. When our minds are threat or stress focused, it is postulated to impair social connection, compassion and pro-social behaviours.

While a detailed explanation is beyond the scope of this review, a few key points about stress are highlighted. When we are exposed to a stressor, as it could be perceived by staff working on an acute impatient ward, it is the hypothalamus in the brain that perceives it. It first activates the autonomic nervous system (ANS), which consists of the parasympathetic (relaxed) and the sympathetic nervous system (arousal). It also stimulates the HPA axis and releases corticotrophin releasing hormone (CRH), and secrets arginine, vasopressin (antidiuretic hormones, (ADH)). At alarm stage, sympathetic arousal prepares the body for our flight or fight response by releasing cortisol, nor-adrenaline and adrenaline from the adrenal glands in the kidneys. This raises the heart rate, blood sugar and blood pressure. At the episodic stage, if we are still experiencing stressors, continuous secretion of these stress hormones provide energy in order to help us adapt to the situation. However, this significantly disrupts the homeostasis in the body, and we can experience problems such as sleep difficulties, fatigue, muscle pain, minor infections, gut issues, and allergies (Van der Kolk, 2014). Cognitively and emotionally, this can lead to a lack of concentration, and irritability and impatience.

If all goes well and we are no longer experiencing stressors then we go onto the recovery stage, and this is the activation of the parasympathetic nervous where the brain and body can repair and rejuvenate. The vagus nerve is implicated in the stage, as vagal activation slows down the heart rate, induces calm states, and facilitates affiliative processes, social connection and bonding (Porges, 2001, 2007 in Gilbert, 2017. Pg 122-123). If the stressor persists and is long term, it is chronic stress, and gives rise to serious health conditions such as depression, hypertension, and coronary heart disease.

The Impact of acute and chronic stress are high levels of anxiety, irritability, rumination and low mood, exacerbated with fatigue, sleep disorders, pain and or discomfort. Also, there are likely to be problems with memory, attentional problems and poor concentration (Van der Kolk. 2014 pg. 46). Despite stress being associated with negative connotations, our stress responses can also be positive, i.e., they can incentivise, motivate and excite us. However, it is important to note that stress responses are not homogenous and differ according to individual difference, such as age, gender, personality, physicality, mental health and past experiences.

Whilst the precise mechanisms of the brain states that are involved in compassion are still trying to be understood, research has yielded some interesting findings, for example, in a review by (Shirtcliff et al, (2009) in Gilbert, 2017) it was found that a lack of ability to activate stress responses, in response to a social stressor or in witnessing the distress of another, increased 'trait callousness' which compromises empathy and compassion. Interestingly, the same review found that in children, adolescence, and adults who had low levels of cortisol also displayed a lack of empathy. It is clear from this that stress is implicated in compassionate mentalities. Importantly the compassionate mind framework understands distress within an individual's social context and relationships, and highly likely to be relevant for individuals who work in acute inpatient settings.

Literature Review

Studies of Compassion in Mental Health Nursing

The majority of studies on compassion originate from the UK or the US, with a few international studies. The literature base on compassion, conceptually, and as a broader concept,

has seen a rise in prominence over the past decade; and especially more so in the past five years. Compassion has either been looked at in terms of its qualities and attributes, and/or from a psychological perspective. The concept of compassion has been more widely studied within the clinical healthcare literature, but much less so within mental health nursing. The literature for the latter has predominantly focused on compassionate mind treatment formulations that have targeted affect dysregulation in clinical groups such as in depression, eating disorders, or psychosis, (Gumley, et a., 2010), which have had promising results (Morrison et al., 2004). Surprisingly there are very few studies situated within acute inpatient settings, which is striking considering compassion has consistently highlighted in governmental reports, as well as being cited in the service user literature by patients and families of its value to them, as well as the importance of compassion in clinical care and outcomes (Sinclair et al., 2016). As mentioned, the majority of studies in this area has historically focused on constructs such as morale and burnout, which can materialise as a consequence for staff working in this area mental health. The scope of this review will be limited to the research conducted within healthcare settings that are deemed applicable, but with a predominant focus on nurses and/ or acute impatient wards. Key search terms included 'Compassion', 'Nursing', 'Staff', 'Experience', 'Acute', and 'Inpatient'. Not all articles contain all of the searched terms. Non-clinical populations and studies on self-compassion, compassion fatigue and empathy are excluded.

Compassion in the NHS has had a complicated narrative. In the nursing profession it has been conflated with interchangeable terms such as kindness, caring, or empathy as well as other lay terms (Gotz et al, 2010; Schantz. M, 2007; Burnell. L, 2009; Strauss et al, 2016). A lack of conceptual clarity of how compassion is defined and understood, as well as a lack of understanding of compassion in mental health poses a significant problem for researchers, therefore the evidence base for compassion in healthcare remains underexplored (Dewar, 2011, Spandler & Stickley 2011, Brown et al, 2013; Sinclair et al, 2016).

The time needed to be compassionate also featured in the literature and played a part as a function of participants nurse's understandings of the nature of compassion and its development overtime, i.e., having enough time, or giving more time, and the timing of information given, formed part of conceptualisations of compassion in this group (Bramley & Matiti, 2014; Armstrong et al, 2000; Sanghavi, 2006; Lown et al, 2011).

Additionally, certain antecedents of compassion were found in the literature and described as 'innate qualities' that healthcare clinicians might have prior to their training, that were deemed relevant as acting as a baseline for compassion (Sinclair et al, 2016). For example, qualities such as respect, dignity, care and kindness, and as part of a clinician's demeanour were cited by families and caregivers as being antecedents to compassion (Bramley & Matiti, 2014; Lown et al, 2011; Badger & Royse, 2012; Lloyd & Carson, 2011). Clinicians described virtues of care such as honesty and fairness as being antecedents to compassion (Armstrong et al, 2000; Skaff et al, 2003).

A point of debate within the literature centres on whether compassion can be taught, which varied within the literature, however there are some agreement that it may be possible to encourage and instil compassion over time, but that it is dependent on baseline qualities (Bramley & Matili, 2014; Bray et al, 2014; Vivino et al, 2009).

Some studies cited their capacity for compassion as having been influenced by elements of their clinical training such as personal and professional development, as well as citing external factors such as early influences, family illness, faith, and personal experiences of being recipients of compassion themselves.

Van der Cingel, M (2011) when looking at compassion and older people with chronic diseases and nursing, found seven dimensions associated with compassion which include being present, understanding, helping, listening, attentiveness, involvement and confronting.

In in interesting study, Bramley & Matili, (2014) looked at the meaning of compassionate nursing care from the perspective of patients in a qualitative study (n = 10). Compassion was defined in this study as 'knowing and giving me your time'. They identified three themes: the impact of compassion, communication and the essence of nursing, and understanding compassion. They identified that the words care, and compassion were used interchangeably with equal frequency, and that compassion was described my patients in terms of touch received within one-to-one interactions. Additionally, giving time was deemed instrumental to compassion, and that the relational aspect of compassion can't be overlooked when

implementing care. They also found that patients emphasised a need to be understood by nurses about how it feels to be treated in uncompassionate ways. Communication between patients and nurses was deemed important, through verbal or non-verbal means, but that communication was integral part of compassion. To enhance the trustworthiness of the study they engaged in peer checking and reflexivity to negate personal biases, and also used a research diary to underpin the rationale and process of the research. However, it's debatable and open to interpretation the idea of gaining insights regarding compassion in nurses from a patient perspective, as well as some scepticism among mental health practitioners citing that data gathered during a time when patients are unwell may be symptomatic of their mental health difficulties and therefore difficult to make accurate interpretations (Rose, 2001). Additionally, although a small sample size can lead to deeper and richer insights, it can also limit the transferability of the findings. They acknowledge that having only white British participants groups were not representative. The participants were also identified by other nurses, who may already have views on which patient is likely to be compassionate or not. Additionally, using very ill patients can render their views of compassion to be dependent on their vulnerability towards the nursing care they are receiving. They conclude that further research that compassion can be conveyed in fleeting manner and rather than dependent on relationships is required.

In an influential study, Crawford et al, (2014) examined the language compassion in the interview narratives of staff working in two acute psychiatric units. The study design utilised a mixed qualitative and quantitated design, using corpus-assisted discourse analysis. They define compassion as being sensitive to the needs of others and showing a commitment to relieve it. The two units housed patients who are experiencing bipolar, schizophrenia, and severe depression. They recruited participants (N =20) which included a combination of consultant psychiatrists, ward managers, ward sisters, healthcare assistants, staff nurses (N = 8) and (N = 1) staff nurse. Using standardised semi-structured questionnaires, they were asked about the meaning of compassion, the qualities of a compassionate person, and the role of compassion in mental healthcare. They used computer software (AntConc 3.2.4w) to analyse and identify frequently occurring words and phrases in the data. To support claims in the data they used word frequency lists as diagnostic tools to support data from the discourse analysis (Adolphs et al., 2004; Louw, 1993). The participants were interviewed using a standardised semi-structured

questionnaire and were asked about the meaning of compassion, the qualities of a compassionate person, and the role of compassion the mental healthcare. They found 28 attributes of a compassionate mentality in the interview data, of which caring, helping, giving, supporting, and understanding were the most common. However, they found only 218 lexical variants of the above attributes, featuring at only 0.67% of the total language used, including that evidence for compassionate language is minimal. The study also found even when compassionate language was used, i.e., care (n = 48) it was cited more in relation to the systems or processes in the hospital. Out of 90 instances of care, only 19 were aligned clearly with compassionate commitment to a patient as outlined in their definition. These results are surprising considering the interview topic. Additionally, words such as paperwork (127), help (152), and understanding (166) featured higher than compassionate mentality words, even when help and understanding were used, they were used in relation to explaining away a problematic behaviour originating from their patients, for example "I can really understand what they get fed up". The authors cite that the language used predominantly focused on time pressures, care processes, emotionally distancing terminology, and organisational tensions in a way that could give rise to a "production line mentality" that compromises compassion as well as high quality care. Additionally, terms related to compassion such as kind, gentle, warm, and friendly were used very infrequently in this study. Although this study had a small sample size and therefore difficult to generalise, its small sample size can also be valuable in assisting discourse analysis to produce deeper analysis and targeted study that would have been difficult to generalise otherwise. This is the only study that the authors are aware of that has focused on staff perspectives of compassion in acute impatient wards, highlighting the need for much more research in this area.

A study by Brown et al, (2014), that used the same data and participants from the above study, examined practitioners accounts of how they 'formulated, interpreted, and deployed' the concept of compassion and its practice in their daily work. The interviews sought to find out how compassion was constructed, what it means, the qualities of a compassionate person, and the role of compassion in mental healthcare. The interviews were analysed using a constructionist discourse analysis (which looks at written and spoken language in relation to social context). The authors identified commonly used 'interpretative repertoires' common in all of the interviews and coded them. They found two repertoires, a practical compassionate

repertoire (i.e., physical, practical, or embodied aspects of compassion), or they used organisational repertoires, with the latter inhibiting compassionate care. The first one was marked by practical components in attempting to define compassion, such as planning interactions with patients, like playing games, or taking them out for a cigarette, and/or anticipating any changes to the needs of the patients. Participants described that these practical repertoires encouraged engagement or 'opening up' between patients to better facilitate compassionate mental health work to occur. The second one was marked by organisational repertoires which were organisational issues that inhibited compassionate practice. The organisational issues included time spent on administrative tasks or staff shortages that detracted time away from patients. This study illuminated that for these participants compassion was not operating through internal motivational systems (as discussed earlier), but rather though action which is particularly noteworthy.

Spandler and Stickley (2011) suggest that it is helpful to view compassion not just from an individual perspective, but also through 'contexts, relationships ,cultures and healing environments'. They cite that compassion should be 'nurtured in context and through cultures. As mentioned, compassion operates through relationships and is shaped by contexts and environments, so therefore it seems important to contextualise and find out the experiences of compassion for inpatient nursing staff within the context of an acute inpatient setting because it is likely to be relevant for patient care and mental health recovery.

Resilience

The role that resilience plays is worth a mention in this context. Individual difference plays a role in why some nurses do not go on to develop burnout, and experience minimal setbacks that are likely to compromise their ability to be compassionate. Resilience has been described as a process as well as an outcome (West et al., 2017; McGown. J, 2016).

Resilience has been identified as adaptive process, to not only overcome challenges and adversity, but also to thrive while doing so (West et al, 2017). It is an under researched area in nursing (McGowan. J, 2016). It has been viewed from a trait or personality characteristic (McGowan, 2016). It can be nurtured by having hope, coping strategies, and self-efficacy

(Rushton et al, 2015). Hardiness, Postive relationships/social support/ Flexibility/ sense of humour/ self-esteem (Earvolino-Ramirez, 2007).

Rushton et al., (2015) conducted a quantitative cross-sectional survey design (N = 114), with nurses in high intensity settings with a specific lens on burnout and resilience. Participants were from six high stress units (two paediatric, two oncology and two adult critical care units). Consideration was given to match measures such as patient characteristics, security, and staff turnover. Survey measures included the: Maslach Burnout Inventory, a moral distress scale, a perceived stress scale, a resilience scale, and the state hope scale. They found that moral distress (an incongruence between one's values and actions) significantly predicted all three aspects of burnout (emotional exhaustion, depersonalisation, and reduced personal accomplishment), and that burnout and resilience had a strong association. They also found that increased resilience inoculated nurses from emotional exhaustion as well as enhancing feelings of personal accomplishment. A sense of spiritual grounding also played a role in reducing emotional exhaustion and depersonalisation. Physical well-being was also found to be associated with increased personal accomplishment. Having more resilience was also implicated increased hope and a reduction in stress. Although not directly a research question resilience is likely to moderate inpatient staff experiences and possible expressions of compassion within the context of what has been documented as a stressful working environment.

Rationale and Relevance to Counselling Psychology

There is increasing awareness of the importance of affiliative relationships and social processes in psychological well-being, of which underpin compassionate mind frameworks. (Danquah & Berry, 2013). The rationale for the usefulness of compassionate mind frameworks stem from the importance that affect dysregulation plays in many trans-diagnostic difficulties experienced by patients in acute inpatient wards, with it increasingly being integrated as part of mental-health recovery models (Gumley et al., 2010; Braehler et al., 2013). Frontline staffs play a prominent role in the service user experience of affiliative relationships in an acute setting, of which there is little research, and a lack of theoretical integration in the field. However, we know that staff also experience their own difficulties with emotional processing and are unable to respond compassionately toward patients. Studies in this area have tended to focus on

healthcare as well as compassion experienced from patient experiences. There is a gap in the literature looking at the role of compassion and its utility for inpatient nurses in acute inpatient wards, of which this study hopes to address. Understanding staff subjective experiences of compassion, and the factors involved in compassionate responding, in this small study may yield to some unique perspectives on how compassionate mind theories maybe relevant for staff managing their own threat-based processing within an acute inpatient setting. Gaining more knowledge about how compassion is experienced by staff, may add to the research, training, and practice in this area, and indirectly benefit patients. This area of research has predominantly been dominated by the medical model, emphasising diagnosis. There has been minimal engagement from counselling psychologists in this area, with service user literature only recently gaining traction in this field. Counselling psychologists are best placed in promoting interdisciplinary research, as well as integrating various theoretical models as has featured in this review, in order to yield deeper, richer unique perspectives of the thoughts and feelings of how compassion is experienced by staff. The relevance to clinical practice is that it can provide a better understanding of a system wide understanding of compassion, within this particular context, to support the creation of psychological therapies. In this view Counselling Psychologists should be well-placed to deliver effective interventions that take into account evidence-based research as well as a subjective reflective practitioner lens that hear all voices (Kasket & Gil-Rodriguez, 2011).

CHAPTER 2 – METHODOLOGY

Overview

In this chapter, I discuss the interrelated philosophical values, theoretical ideas, and methodological principles that have been operationalised in my research. I explain my rationale for choosing a qualitative research approach, and more specifically my rationale for adopting to use Interpretive Phenomenological Analysis (IPA), a qualitative inquiry, to examine staff experiences of compassion, in an acute inpatient setting. In conjunction, I offer and review my epistemological stance, which underpin my research and the above choices; and also give a detailed account of how my research was conducted and my reasons for doing so. Finally, considerations about the quality, validity, and integrity of my study are discussed, as well as methodological reflexivity. Links to my identity as a counselling psychologist will be made throughout as well as to the profession as a whole.

Qualitative Research Approach

Mainstream psychology, has traditionally been synonymous with quantitative research methods, initially hinged on *positivist* but subsequently repositioned, by *post-positivist* research paradigms (Ponterotto, 2005). Positivist paradigmatic assumptions, which are nomothetic, believe that 'there is a real world that we can gain knowledge about' and that the knowledge has to be 'objective, scientific, quantifiable, and generalizable' (Landridge, 2007, p.3; Willig, 2008, p; Ponterotto, 2005; Hood & Johnson, 1997). Post-positivists agree that there is a real world out there, but that that our knowledge of it is 'skeptable, incomplete and fallible' (Landridge, 2007, p.3; Gray, 2009, p.23). Positivists do not consider the role of the researcher (from an empiricist viewpoint) or intersubjectivity (between people) in the generation of knowledge (Willig, 2008, p.3; Landridge, 2007, p.3), and is therefore seen as 'reductionist' (Willig and Stainton-Rogers, 2013, p.6-7).

Contrastingly, and somewhat complimentary the development of qualitative research methods has emerged to address these concerns. It 'rejects subject-object dualism'; and a 'separation the world, from its objects from our subjectivity and perception of them' as redundant (Landridge, 2007, p4). It seeks to gain access to new richer meanings, which incorporate historical and sociocultural aspects of knowledge (in context-specific settings) via descriptions, the use of

language, and interpretation (Landridge, 2007, p.3; Denzin & Lincoln, 2000b in Ponterotto, 2005; Willig and Stainton-Rogers, 2013, p.6-7).

As qualitative methods seek to explore 'the quality and texture of experience and not cause-effect relationships' (Willig, 2008, p.8), it is congruent with the ethos of counselling psychology which seeks to explore in-depth the 'multifaceted nature of the complex processes of human phenomena' (Morrow, 2007), and also recognises that 'divergent research methodologies can be equally valid in exploring important questions' (McAteer, 2010. p.8). Qualitative methods also have intuitive appeal to counselling psychologists as it lends itself to the' narratives of therapeutic work' (Morrow, 2007). Qualitative methods also have their criticisms (Willig, (2008); see Burr, 2003 for a full critique), but seemed the most appropriate choice to use for this study given my lens as a counselling psychologist and with the aims of my research question.

Overview of Interpretative Phenomenological Analysis and Philosophical underpinnings

Interpretative Phenomenological Analysis (IPA) is an interpretative approach that is increasingly being applied in psychological qualitative research. Developed by Johathan Smith in 1996, it has assumed an authoritative position in qualitative research, and focusses on attaining an in-depth and holistic understanding of human life experiences. It is pluralistic in nature and recognises the importance of combining experimental and experiential aspects of research in psychological enquiry. Larkin et al (2006) discuss IPA as having three main theoretical underpinnings which include a 'phenomenological requirement' (which 'give voice' to an individual's experiences); an 'interpretative requirement' (also known as hermeneutics which contextualises and 'make sense' of these experiences from a psychological perspective of the phenomenon); and has an idiographic focus (which allows for a deeper understanding of the complexities of individual experiences). In other words, it is predominantly concerned with understanding lived experiences and making sense of those lived experiences.
I will now discuss these three main theoretical underpinnings in greater detail below.

Phenomenology

It is a philosophical movement developed and founded by Edmund Husserl ('who advocated a return to things themselves'. These ideas were further developed by Martin Heidegger (Landridge, 2007). Husserl believed that it was not possible to examine and encompass 'subjective human experience' under the principles used to study the natural sciences (Brooks, 2015). He identified phenomenology as a rigorous alternative method where he put forward that our understanding of an objective reality is flawed, without incorporating our 'lifeworld' which encompasses how phenomena appears to us as conscious beings (Brooks, 2015). The world as it appears to us within a particular context and time is referred to as transcendental phenomenology (Willig, 2008, p.52). Additionally, Landridge (2007) states that 'our perception varies according to context'. Brooks (2015) describes Husserl's understanding of the 'lifeworld' (everyday life phenomenon) as 'pre-reflective' where emphasis is given to what is being perceived rather than how it is being perceived.

Husserl in his work isolates essential structures of experiences and tries to describe these as precisely as possible by adopting a 'phenomenological attitude' known as *epoche* ('bracketing') (Brooks, 2015 and Finlay, 2012, p.175). *Epoche* is a process or a 'phase of contemplation' which is suspending of our preconceived assumptions and judgements about the external world; it is achieved through 'phenomenological reduction'. Therefore, essentially illuminating the experience as it was originally meant to be presented to us through consciousness i.e. with a 'natural attitude' (Willig, 2008, p.53).

Landridge, (2007, p.15) refers to the idea of intentionality, where what is experienced (noema) is distinguished from the way it is experienced (noesis). Intentionality is a way of describing and understanding the world of objects and subjects as part of one's experience with the self and world intertwined and indivisible. Perception is dependent on 'location and context, angle of perception and the perceiver's mental orientation' e.g., wishes, emotions and aims. Perception is believed to be intentional and an embodiment of the experience itself (Willig, 2008, p.52). However, the extent to which Husserl's transcendental (descriptive) *epoche* is achievable is contentiously debateable not only within IPA but also within other phenomenological approaches (Brooks, 2015). As a consequence, Heidegger, Sartre and Merleau-Ponty introduced the concept of hermeneutic or existential phenomenology with the aim to address fundamental or ontological questions of existence (Smith et al, 2009, p.21).

Heidegger believes that humans cannot be separated 'from the world in which they exist' and this relation is always referred to as both 'interpretative and relational'. Hence in order to attain a proper understanding of reality we need to consider the 'bigger picture' which can be influenced by multifactorial entities (e.g., language, culture) (Brooks, 2015). According to Eatough and Smith (2008, p.180) Heidegger posits that 'a human being is a *Dasein*' which literally means 'being there' or as 'being-in-the-world'. This notion encapsulates the concept of Cartesian dualism of 'person/world, subject/object', mind/body'.

Hermeneutics (Interpretative IPA)

This a methodology of interpretation used to interpret philosophical text. It provides a -valuable way of considering the 'method' for researchers using IPA. Hermeneutics, is a theory of interpretation but also underpins IPA in addition to phenomenology, developed as a prerequisite to phenomenology critical to the interpretation of using written text and the role of the researcher to go beyond surface level description of the text and attempting to make sense of the individual's experiencing of a particular phenomenon (Frost, 2011, p.47). According to Moran (2000:229) Heidegger proposes that the meaning of hermeneutics is in 'the whole manner in which human existence is interpretative' therefore Moran believes narratives must be explicitly studied in their presenting form (Frost, 2011, p.47).

Essentially hermeneutics enables a researcher to uncover and illuminate the intentions of the described writings and situate it within a wider social, cultural and theoretical context (Larkin et al, 2006). Empathic and Suspicious hermeneutics are interpretative stances which are specifically used in IPA and proposed by Paul Ricoeur (1970) to expand and broaden the understanding of textual interpretation (Langridge, 2007). IPA employs empathic hermeneutics with suspicious hermeneutics as interpretative stances which allows the researcher to capture a balance between attuning to and understanding the participant whilst maintaining a critical and analytical perspective of the text. Ricoeur along with Marx, Freud and Nietzsche all claim 'meaning is never apparent but instead is beneath the surface and in need of unmasking' (Langdridge, 2007, p.50). Theorists that further contributed to these ideas are (which will be explained in the analysis section) include Schleiermacher, Gademer and Heidegger (Smith et al, 2009). Schleiermacher posits that understanding subjective discourse depends on the interpretation of language and thought. He explains that both linguistic and psychological

interpretations are key in order to have a holistic understanding of spoken or written textual accounts by allowing researchers to go beyond mere descriptions of the text (Smith et al, 2009, p.22-23).

Gadamer focuses and builds on Heidegger's hermeneutics. He emphasises the historical and sociocultural elements influencing the interpretative process in cognizance of the relationship between the 'interpreter' and the 'interpreted' (Smith et al, 2009, p.25). As meaning and linguistic understanding is embedded in language 'things can only come into being only through language' suggesting that things are not static and are constantly changing (Langdridge, 2007, p.51). He recognises humans 'being- in-the-world' as predating language and human nature is understood through language (Landridge, 2007, p.53).

Gadamer's dialogical character can be characterised through Heidegger's hermeneutic circle. It is based on establishing a 'dynamic relationship between the part and the whole' and to gain clarity on any given part one must consider the whole and vice versa (Smith et al, 2009).
As IPA foregrounds the idea that the researcher can have no direct access to the inner experience of the participant, meaning can only be constructed through an interaction whereby the researcher is trying to make sense of the participant's attempts to make sense of their experience – a double hermeneutic (Smith & Osborn, 2003). In other words, the analysis is seen as a co-construction between the participant and the researcher (Smith & Osborn, 2003). It is the dynamic of addressing the epoche.

Idiography

Idiography is distinctive to an IPA approach and is contrasted to nomothetic mainstream psychology in that it is committed to the particular, individual understanding as opposed to generalizable understandings (smith et al, 2009, p.29). Its commitment is realised on two levels; one is through a detailed, line-by-line systematic analysis of the text; and the second is through the understanding of particular phenomena from the subjective viewpoint of the individual within their specific context (Smith, 2009; p.29). IPA is a flexible, iterative account. In other words, through the systematic understanding of one account, the researcher is able to use this as a starting point to gain subsequent understandings of the more general experience.

Epistemological standpoint

Epistemology, within qualitative approaches, provides a philosophical stance for deciding what kinds of knowledge can be produced about the world, and 'how it is acquired or constructed' (Coolican, 2004, p.559). It is consciously selected, and considers how we construct knowledge intersubjectively, in other words between the 'researcher' and the 'participant' (Langdrige, 2007, p.?). Epistemological positions range from a naïve realism to radical relativism (Madill et al, 2000; Willig, 2008, p.12). Realism at one end is aligned with a positivist's, nomothetic ontology (advocating dualism); while a relativist ontology, at the other end, rejects concepts such as 'truth and knowledge', and maintains that the world is not the 'orderly law-bound place that realists believe it to be' and is socially, culturally and linguistically constructed (Willig, 2008, p.13). There is a perspective called critical realism (a post-positivist and a modified form of dualism) (Bhaskar, 1978) that can be found in between these two endpoints which combine a realist viewpoint and believes that there is a 'true reality one cannot fully apprehend' (Morrow, 2007); while at the same time 'accepting that there can be alternative valid accounts of any phenomenon' (Maxwell & Mittapalli, 2010, p.150). Therefore, critical realism 'retains an ontological realism while accepting a form of epistemological relativism or constructivism' (Maxwell & Mittapalli, 2010, p.151). This position is closely aligned with my own axiology and is relevant for my choice of using IPA methodology.

As summarised IPA's philosophical underpinnings stem from phenomenology and hermeneutics, social constructionism (Willig, 2008, p.184), symbolic interactionism (Mead, 1934 cited in Willig & Stainton-Rogers, 2008, p.184) and social cognition (Fade, 2004). IPA as a methodology, is free from epistemological obligations, however it can be said to be theoretically routed in critical realism. IPA assumes that participants can make sense of their own objective reality but that they do so in radically different ways because each experience is influenced and mediated by individual differences and their perception of that experience (Willig, 2008). This perspective can be aligned with the philosophical underpinnings of IPA and that of my research question and aims. It supports the idea that compassion is an objective truth or reality, whilst accounting for the idiographic understandings of staff member experiences of compassion and the various ways it may be perceived or constructed within the lifeworld.

Critical realism is said to have overlapping features with constructionist positions that align with relativist ontology, in that it considers numerous realities of experiencing (Madil, Jordan and Shirley, 2000). Contextual constructionists view human experiences (mediated historically, culturally and linguistically, Willig, 2008, p.7) and perceptions as socially constructed, in that objective reality cannot be segregated away from the person who is 'experiencing processing and labelling that reality' (Sciarra, 1999 cited in Ponterotto, 2005). In other words, participants cannot be removed from their objective reality as Larkin et al (2006, p.106) states that 'it is not possible, even if it might be desirable - to remove ourselves, our thoughts and our meaning systems from the world' in an attempt to make sense of how things 'really are'. Knowledge from a contextual constructionism viewpoint is 'not a direct reflection of environmental conditions but understood as a specific reading of these conditions' (Willig, 2008, p.7). Research outcomes are therefore dependent upon the context and situation in which data is gathered; and therefore, can produce differing 'knowledges' rather than 'knowledge'. In other words, the same phenomena and its hidden meanings can be brought to the surface from a variety of different viewpoints (Willig, 2008, p.7).

My own position with reference to IPA adheres to and aligns with a critical realist perspective with a contextual constructionist epistemology. As a researcher I adhere to the fact that human experiences are socially constructed i.e., staff experiences of compassion and can be influenced by the socio-cultural and historical processes. I also accept that I can only have partial and incomplete access to my participant's experiences and therefore I can only focus on the 'person-in-context', who in this case is influenced by context (Ponterotto, 2005). Bhaskar argues that reality is not just evident in things but can also include structures e.g., the organisational context of the acute ward that can have an effect on things (Porter, 1996); in other words, a critical realist position can include considerations about the rejections of the 'etic' perspective in phenomenology.

Epistemological Reflexivity

Epistemological reflexivity discusses the role of theory in the interpretation of the participant's data. It involves a consideration of how the phenomena being researched could have been explored differently. This is informed by our theoretical framework, which is further informed

by the epistemological position that we have adopted (Willig, 2008, p.10). Although IPA was selected as a methodology for my research aims, this approach is one of several that were reviewed. Grounded Theory (GT) and Narrative Analysis (NA) were each compared and contrasted with IPA.

Grounded Theory (GT) vs Interpretative Phenomenological Analysis (IPA)

The aim of GT is to produce new theories grounded in the data. They synthesise data from a number of different sources that are compared and reviewed to generate new emerging theoretical concepts, but always grounded in the data. It is concerned with building a new theory from the data as well as with generalisability. This approach had the greatest appeal because it describes and explains contextualised social process (social psychological or social structural in nature) and their consequences for participants (Willig, 2008, p.45). However, due to its relativists ontology it assumes that social processes occur irrespective of the researcher and can be 'known'. It assumes that knowledge is created via the participants interaction with 'the world' i.e., it produces knowledge of processes that are in and can emerge from the data. The role of the researcher is divorced from the analysis and assumptions/expectations are secondary (Willig, 2008, p.48). Additionally, it does consider a social constructionist perspective and sees itself as a social construction of reality (Willig, 2008, p.49).

GT is useful for discovering the types of problems exist in a social sense, and the 'processes' a person employs to handle them whereas IPA is concerned with subjective and experiential psychological accounts and therefore has as an idiographic focus rather a contextualised or dynamic approach to chart social processes/relationships in the wider context. GT shares similar features with phenomenological component of IPA. GT takes the view' from the outside in' whereas IPA proceeds 'from the inside out' (Charmaz, 1995 cited in Willig, 2008, p.45). IPA is more concerned with the psychological texture and quality of the participant's experiences and perspectives rather than 'its social causes or consequences' (Willig, 2008, p.45). Although social processes are inherent in this research question, and has been commonly used within nursing studies, this research focussed more on the phenomenological enquiry of the experiences of compassion for those working on an in-patient acute ward. Ideally as suggested by Willig (2008) both GT and IPA can be combined in an attempt to capture 'lived experiences'

and offer greater understandings of the quality of the 'lived experiences' and to contextualise it in the wider social processes. Ideally and without time restrictions a combination of these two approaches would provide a more comprehensive understanding of the social psychological phenomena (Willig, 2008, p.45). IPA was decided upon as the most suitable as there is not as far I am aware an existing understanding of staff experiences of compassion or their understanding of compassion within an in-patient acute ward, and for relevance and applicability it seemed an IPA methodology would be able to contribute to this literature base and to offer deeper understandings to existing positivists studies in this area.

Narrative Analysis (NA) vs Interpretative Phenomenological Analysis (IPA)

NA focusses on the discriminate ways, in which participants tell and interpret their stories ('stories' and 'kinds of stories') about their experiences of a particular phenomenon. Telling a story helps us to organise our thinking about a particular event or phenomenon. NA offers an organised interpretation of the sequence of events of a story i.e. it's structure (beginning, middle or end) in order to derive meaning about its functions and its social/psychological implications' (Willig, 2008, p.133). However, understanding compassion from a subjective perspective as opposed to understanding the structure of experiencing compassion was seen to have more utility in this present study. NA captures experiences generated by social interactions between participants and drawn from a smaller restricted sample. It does not capture privately created experiences of which this study is concerned with (Smith & Sparkes, 2008 cited in Frost, 2011, p.94). Contrastingly IPA allows for a deeper and richer understanding of participants unmediated personal experiences, drawn from a larger sample which can assess the similarities and differences between the participant experiences (Frost, 2011, p.94)

Validity and Reliability

Willig (2008, p.16) defines validity as 'the extent to which our research describes, measures or explains what it aims to describe, measure or explain'. Yardley (2000) proposes four flexible and essential characteristics as a guide to which qualitative research studies can be assessed by. They include sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The above characteristics were chosen to assess my research.

Sensitivity to context

This particular characteristic was demonstrated via a thorough literature review of the theory and empirical data relevant to staff experiences of working on an in-patient acute ward as well as familiarising myself with the relevant literature base of compassion. An aspect of sensitivity to context is having mindfulness about participants' perspective. I was aware that due to the rigorous demand of working on an in-patient ward that the availability of staff nurses to set aside a one-hour slot for the interview was dependent on the unpredictable circumstances of the acute in-patient environment on any given day. I planned my interview schedule according to the availabilities of the nurses and more often than not was happy to reschedule the interview slots on different days and/or different times. I was also sensitive to the fact that although there was an interest and willingness of the participants to free up their time, it would still require them to allocate time away from their busy schedule. Therefore, I made every endeavour to provide hot and cold beverages and snacks in order to help them to feel at ease and to provide an informal interview environment. Additionally, I was able to secure a quiet room within the hospital but away from the participant's in-patient ward environment. I made special considerations to avoid booking interview rooms on any in-patient wards that my participants were working with the aim to provide a calm, quiet and reflective third space. This was to facilitate a clear 'thinking' space to minimise any distractions. I was mindful of the influence of power dynamics between the participant and the researcher, as well as the wider organisational factors such as job insecurities and to alleviate any concerns about confidentiality, I provided reassurance that the data collection and their personal identities will be kept anonymised (reiterated by the provision of a participant information sheet).

Commitment and Rigour

Yardley's (2000) second characteristic states that good research should show 'commitment and rigour. He is referring to in-depth engagement with topic (prolonged engagement with the topic), methodological competence and skill, thorough data collection and depth/breadth of analysis. Refer to thoroughness of data collection, analysis and reporting.

I have had prolonged engagement with this present study initially through the theory and development of Compassion Focused Therapy (CFT) as part of my academic studies, and

subsequently through my final year placement having used CFT as part of group work with inpatients on an acute ward. These two exposures, and having had identified a gap in the research through an initial review of the literature propelled me to identify my research question in exploring staff experiences of compassion .To further embed myself in this research area I joined a Compassionate Mind Special Interest Group (SIG) at University College of London which enabled me to discuss the potential applicability and utility of my research and gain valuable access to experts and peers in the field and to exchange ideas.

I have followed detailed R&D procedures for North East London Foundation NHS Trust as well as the research ethics and guidelines of City University in the design, implementation and analysis of this study. In terms of rigour and demonstrating the completeness of my research I have selected a suitable IPA methodology and an adequate sample of participants to provide me with sufficient interview data in order to provide an in-depth analysis of my research question. Although starting out as a novice researcher in qualitative methods, I have increasing gained enough competencies and skill using IPA in order to offer an analysis that is detailed, interpretative, coherent and one that does justice to, and 'gives voice' to the complexities of my participants experiences.

Transparency and Coherence

Yardley's (2000) third characteristic as a criterion for which to demonstrate good research is 'transparency and coherence'. In terms of the coherence of this present study I have aimed to produce a narrative that is meaningful and engaging to the reader, and one that also allows the reader to follow the research from its epistemological underpinnings right through to the chosen methodology, method, analysis, and finally through to the discussion, implication of findings, and a dissemination of the results. In terms of offering an open and transparent account of the research process; all relevant data including audiotapes, transcripts, free-associative notes, and hard copy paper analysis have all been saved in order to be auditable. Additionally, it has been argued that the process of supervision itself can provide a means to vet the validity of the research through having a third-party offering expertise, witnessing the process, as well as providing written and verbal feedback for the analysis and each stage of the research process (ref). Moreover, reflexivity as a requirement for this type of qualitative research has been

provided in the form of a reflective statement of the research process in order to further enhance the validity of the study.

Impact and Importance

Lastly, Yardley's (2000) final characteristic for good research assesses the 'impact and importance' of the research. This has been demonstrated by picking a research area that is current and gaining in its research base but has been mainly associated with quantitative methods. Furthermore, the research base on inpatient wards has also been emerging in recent years. This present study aimed to open up new ways of understanding compassion from a staff perspective that has previously been overlooked and to put 'research-in-context' (Yardley, 2000).

Research Aims

This study aimed to explore compassion in an acute inpatient setting and how it was experienced by staff. This study will add to the evidence base for compassion by developing a baseline of how compassion is experienced by inpatient staff: what it is, what facilitates it and what inhibits it. The study aimed to explore staff's experience of compassion to themselves, to others (patients, staff, management), and from others. The researcher is interested in representations of compassion from the perspective of staff members. It is a broad exploratory study and will not test a predetermined hypothesis.

Method

Design: A qualitative IPA methodology was used which can enable the exploration of personal meaning (Willig, 2008). As this is an exploratory study a qualitative approach avoids the determinism inherent within quantitative methodologies and will allow for varying understandings of reality.

Participants: *Sample size*: Consistent with the literature recommendations of this chosen methodology, approximately (n=7) staff members working within male acute inpatient settings were recruited to the study (Smith & Osborn, 2003). Participants were recruited from the same professional tier i.e., nurses, to ensure a more closely defined group and homogenous sample and were purposively recruited. A mixture of genders, ages, and ethnicities was sought.

Inclusion Criteria: Participants were required to have been employed within inpatient services for at least 12 continuous months of service, so to ensure authenticity to the study aims.

Exclusion Criteria: Participants were excluded from the study if they were not able to give informed consent, or not able to communicate in English. The exclusion criteria are justified because the ability to give informed consent is a fundamental ethical issue and also may compromise the two-step analysis in which the researcher (English speaking) is also involved in the analysis. The researcher did not interview staff that that have had prior working relationships with the researcher.

Demographics

Age (Years)	**Gender**	**Length of Service as an Inpatient Nurse**
33	**Female**	**1 year 4 months**
36	**Male**	**5 months**
50-59	**Male**	**14 years 6 months**
49	**Male**	**1 year 1 month**
44	**Female**	**6 years 1 month**
47	**Female**	**10 years**
38	**Male**	**9 years 3 months**

Confidentiality/anonymity of data

All interviews/identifying information were anonymised to ensure confidentiality and alias initials used in transcripts. All audio interviews were uploaded immediately after the interview. All participant data was be stored on password protected laptops on password- protected files. All audio files were be deleted upon completion of the study. Electronic transcripts will be securely stored for 5years after the study, as per the Data Protection Act (1998), so that it can be written in peer reviewed journals. This information was included in the information sheet given to participants.

The data was only made available to the researcher, field supervisor, university supervisor, and academic assessors. This information was made available to the participant in the information sheet provided.

The researcher was required to breach confidentiality in light of any legitimate concerns of harm to self or others that arise during the interview. This was clearly stated in the information sheet.

Ethical Approval

Ethical approval was granted by City University. R&D procedures for North East London Foundation NHS Trust was also be sought and granted (see appendix)

Procedure

Potential participants were identified through existing contacts of the researcher already employed within the acute care NHS team, and also through email advertisement. Recruitment took take place across three male acute wards in North East London Foundation Trust. Once identified, participants were given an information sheet (Appendix 1) detailing the study and given sufficient time to consider participation. Once participation was confirmed written informed consent was taken on a consent form (Appendix 2), and the participant was asked to fill out the demographics sheet (Appendix 3). Interviews took place at participants' place of work at a pre-arranged time or at the City University London, at the participant's request. The participant was asked to participate in a 40-minute individual face-to-face interview. A focused, semi-structured interview schedule (Appendix 4) was be used to guide discussion. Participants were informed in an invitation letter and in an information sheet the right to withdraw from the study at any time. They were not obliged to give a reason and there was no disadvantage to them.

Considerations: There are minimal potential risks to participants envisaged by the researcher. The researcher looked out for any signs of upset/distress during the interview. Participants were signposted to team supervision spaces or reflective practice groups to discuss any issues that arise further. A list of support groups was also provided. The researcher was mindful of issues than could arise when interviewing participants that are known to each other, and the possible effects on group dynamics when participants re-join the teams after being interviewed. The researcher also promoted an environment to talk freely and confidentially with a view to not compromise these dynamics. This is one of the reasons that individual interviews were chosen, and not focus groups, as a means of gathering data.

Equipment: The researcher's own audio recorder was used. Transcribing equipment was used utilised from the School of Psychology.

Participant Payment: No payment was offered for participation in this study. Participation was be entirely voluntary.

Pre-Interview Brief

Demographic details were taken at this point, and a conversation about confidentially was initiated and details were re-iterated. I was aware that there may have been some concerns about speaking freely and honestly within the context of their working environment. I made them aware that my research was independent of the systems and processes of the hospital and wider NHS organisation and that their details would be anonymised and securely kept. I adopted an informal style in order to put them at ease and offered them refreshments. They were asked to read through the participant information sheet and consent form in which they also agreed to the interview being audio recorded. They were encouraged to ask any questions at this point and were reminded of their right to withdraw from the interview at any time.

Transcription

I transcribed all of the interviews verbatim and punctuated all of the paralinguistic elements in the interview (Jefferson, 1985 in Landgridge, 2007). Words such and "umm" and colloquial terminology such as "da know what I mean" were also included to stay as close to the participants experience's as possible. I immersed myself in the data at this point and also made comments/free associations in the margins of anything that came up for me as well as my reflections of the interview process. All participants were anonymised at this point, and each transcript was assigned numerically with each number trackable to the original audiotape and participant number assigned on the day of the interview. All data was securely stored, and password protected.

Semi-Structured Interview schedule

Guidelines from Smith and Osborn for IPA were reviewed before the interviews were conducted. My interview schedule was extracted from Crawford et al, (2014) paper (Appendix 4); which conducted a corpus-assisted discourse analysis examining the 'language' of compassion in acute mental health care in the UK. After discussions with my supervisor, it was deemed unnecessary to reinvent the wheel as their interview schedule had already yielded sufficient enough interview data in their study to warrant confidence for its use for my study

purposes (Crawford et al, 2014; Brown et al, 2014). The interview questions focused on the meaning of compassion, the key qualities of a compassionate person, and experiences of how compassion is applied in the workplace. Although the definition of compassion utilised in this study is 'a sensitivity to the distress of others with the commitment to try to do something about it and prevent it' little is known about how it is demonstrated by inpatient nurses within the setting of an acute inpatient ward. The workplace context seems highly relevant because as Bramley et al, (2014) puts it 'compassion is broadly aligned with actions of care'. As mentioned in the introduction section, understanding experiences of compassion *towards* patients (articulated in the interview schedule as compassionate care) may provide valuable insights that may be helpful for inpatient nurses, and thus contributing to the evidence based of compassion that can be utilised in therapeutic ward-based interventions.

There were 6 open-ended interview questions in order to facilitate an interview that was nonprescriptive and one with which afforded the participant a free hand in answering the questions (Smith et al., 2009, Willig, 2008). I was aware that my choice of topic/ interview questions and style of questioning would be influenced by my fore-conceptions and that this had the potential to be researcher-led which would significantly alter the research aims and trajectory of the research (Larkin et al., 2006). I consciously took steps to ask follow on questions based only the respondent's last answer in an attempt to minimise this researcher bias. Another consideration was the use of prompts in the interview schedule. Prompts again are seen as researcher-led, and not strictly keeping in with the line of the exploratory nature of IPA. They were at times necessary to use in order to satisfy pragmatic concerns about the value of the research and its utility (Yardley, 2010). On the whole the prompts were not generally required.

Debriefing

Debriefing, how the participant felt during the interview, and additional questions were answered after the interview. A brief summary of the findings will be provided to participating individuals after completion of the study.

Analytic Strategy

Interpretative Phenomenological Analysis (Smith, 1995) was used to analyse staff members' experiences of compassion. Analysis is achieved through making *interpretations* about the participant's experience, and therefore interrogates the assumptions and socio-cultural influences held by the researcher. As IPA foregrounds the idea that the researcher can have no

direct access to the inner experience of the participant, meaning can only be constructed through an interaction whereby the researcher is trying to make sense of the participant's attempts to make sense of their experience – a double hermeneutic (Smith & Osborn, 2003).

I transcribed the audio interview data verbatim which included all paralinguistic elements of the interviews (i.e., pauses, intonations, hesitations and colloquial phrases) (Jefferson, 1985, in Landgridge, 2007). A table was formatted in landscape and comprised of three columns. From right to left, the columns were headed *exploratory comments, original transcripts, and emergent themes* (Smith, 2009). The transcript was numbered on a line-by-line basis. I attempted where possible to include field notes into the transcriptions of non-verbal communications, impressions, tone, and the participants ability to be forthcoming (Fade, 2004). This was done to authenticate and to contextualise the interview experience, as well as allowing myself to be fully immersed in the data.

In the next stage I read and re-read the transcript all the way through and started to write down my notes and free associations in the exploratory column. I then went through the transcript and noted descriptive, linguistic, and conceptual comments of the data and distinguishing features to capture the experiential quality of the data and ascribed named preliminary themes and placed them in the left-hand side column. This was a considerable and painstaking process, and I was mindful of identifying the themes that were going beyond the descriptive and into the interpretative, and also kept a careful eye on linking this to the original transcript (Smith, Flowers, & Larkin, 2006; Hefferon & Gill-Rodriguez, 2011), and where it was applicable, I tried to use participants own words to stay as true to the original data as possible. I also, adopted a phenomenological attitude in that I made interpretations that formed 'parts' of the transcript based on the context of the 'whole' interview, known as the hermeneutic cycle (Smith, 2009). In the initial stages there was the temptation to jump ahead and interpret the text intuitively as a novice researcher, but with supervisory guidance and in keeping with the process of good IPA, careful attempts were made to adhere to producing interpretations that were systematic, auditable, and grounded in the data. Discussions with my supervisor enabled this process as I was able to obtain outsider consensus on my emergent themes, as per keeping with the ethos of a critical realist position (although I am aware that IPA is epistemologically independent). This vetting allowed me to gain confidence that my emergent themes were grounded in the data. This process was repeated for all seven transcripts.

The next stage involved extracting and listing the emergent themes along with their corresponding quotes in a table. I attempted to do this via an excel spreadsheet. This was with the aim of printing out the transcript and then cutting each one out along with their corresponding quotes in order to work with the data manually. I did this for two of the interviews, but quickly abandoned the idea as it was not the best fit for my interpretative style. It has been argued that IPA can draw on a 'wide repertoire of analytical strategies as long as they can be linked back to the original data (Smith, Flowers, & Larkin, 2006). Instead, I took to pen and paper (and somewhat felt more connected to the participant's experiences) (ref). I attempted to make connections between the emergent themes (cumulative coding) in order to cluster them in a meaningful way, and used the processes of abstraction, subsumption, polarization, and numeration to guide me (Smith, Flowers, & Larkin, 2006; Fade, 2004). This was again a cyclical process, which resulted in emergent themes being clustered in a table, along with references to their original quotes, whilst staying true to the experiential dimensions of the data. These clusters were initially given descriptive labels in order to help me organise my thinking around and served as an interim step before I was able to cluster what was now sub-ordinate constructions of the data into more interpretative and meaningful components. This was done on a case-by-case basis and honoured IPA's idiographic approach.

In the next stage, I used the first case as a pivot from which to code the remaining six transcripts through an iterative process and allowed me to elaborate upon existing themes and add new themes as they emerged from the data which in turn could be checked against earlier transcripts, which was done until a 'saturation' point (Willig, 2008, p.58). At the end of this process a master list was produced for all seven transcripts which captured the shared quality of the participant's experience of compassion.

In the next stage of the analysis, I looked for patterns of meaning *across* the sub-ordinate themes as a whole (integrative coding), in order to look for commonalties to collapse and reduce them further in order to identify the interpretative overarching super-ordinate theme (Smith, Flowers, & Larkin, 2006). I then was able to produce a table linking each super-ordinate theme with its respective sub-ordinate theme (with corresponding line numbers) that can be tracked back to the original data. Existing theoretical models were used at this point to organise how sub-ordinate themes could be conceptualised into overarching super-ordinate clusters (Smith, Flowers, & Larkin, 2006).

Re-evaluating, re-organising, or discarding sub or super-ordinate themes were a continual process. Willig (2008) states that decisions on what makes the final cut for phenomenological conceptualisations of the participants experiencing continue up until the final write up of the analysis. Great care was taken to capture, and to be respectful to the participants lived experiences.

Methodological and Procedural Reflexivity

Finlay (2002a) highlights that reflexivity and demonstrating the researcher's decision-making processes, increases the trustworthiness of the research. In terms of the process of methodological reflexivity, my transition and identity as a counselling psychologist (CoP) from clinical training to a researcher, has evolved and solidified over time. The research question and design of this study were conceived during the final year of my study, and when most of my placements up until this point had a predominately clinical and positivist focus. I was aware of this dichotomy in the shaping of my research question and therefore gravitated toward a qualitative design methodology in advance, in order to, what I assumed at the time, would be a recalibration of this and take me back to a counselling psychology philosophy. Additionally, a qualitative methodology held intuitive appeal, and akin to what I saw as my personal identity, as a counselling psychologist. Hefferon & Gil-Rodriguez (2011) highlight that this can indeed be a novice error; although as I became familiar with the philosophical underpinnings of qualitative research and that of my chosen IPA methodology, I am confident that by using an IPA methodology, my research question on exploring staffs the experiences of compassion 'fitted' into the aspects of the phenomenon that I had intended find out, albeit without, a formal understanding of how this might have impacted the trajectory of the research at the time (Hefferon & Gil-Rodriguez, 2011). When it came down to it, consciously identifying as a critical realist, fitted my axiology, that accepted that there is a 'real' world out there, but that access to it is imperfect, and that we cannot separate ourselves from the context (i.e., we cannot remove ourselves from the world around us). This position (which would ultimately shape the knowledge produced) allowed me to reconcile earlier dilemmas when I was undecided about choosing a grounded theory methodology over an IPA methodology. In this case, I was aware through a review of the relevant literature that 'context' in this case, i.e. the working environment of the acute ward would be a significant factor in my participants experiencing, as being socially constructed; but wanted to understand the participants 'lived experiencing' of compassion 'within' this context, but not separate it. A critical realist position paired with an

IPA methodology allowed me to align this philosophy with the practise of counselling psychology.

During the analysis stage of the research, and whilst learning about what constituted 'good' IPA, I unconsciously adopted a play-it-safe approach and offered descriptive and interpretative sub-ordinate themes with 'short descriptive quotes' to demonstrate the relevance and 'frequency' of the theme (Hefferon & Gil-Rodriguez, 2011), (but as I become more adept with the analysis I was able to be braver and allowed myself to offer a more in-depth interpretative analysis of the data which I felt was more in tune with 'giving voice' and accessed the emotional experiencing of my participant's experiencing of the phenomenon. Supervision further aided this process as I was reminded of going beyond the descriptive but demonstrating an alignment to the original quote in the data. However, it was at this point where I realised that I had made novice epistemological errors in my interview schedule, and although the prompts included were infrequently used in the interviews, it constituted elements of a predetermined agenda. I have made every attempt to focus on aspects of the participant experiencing that were not myriad with my own.

In terms of procedural reflectivity and the interview process, I kept reflective field notes about my own presuppositions and fore understandings in order to remind myself of bracketing them off, so that I was able to be present to prioritising the participant's experiences above my own. After listening to the audiotapes, which I played back after each interview, I was aware that this ebbed and flowed in the first few interviews, and after which was mindful of maintaining a careful balance between 'guiding and being led' (Heffron & Gil-Rodriguez, 2011).

Additionally, with hindsight I am aware that I started the interview with a question that asked, 'what is your understanding of compassion?' which immediately launched into the phenomenon being studied. To what extent this influenced and set the 'parameters' of the investigation towards my agenda I do not know (Hefferon & Gil-Rodriguez, 2011). However, it's important to note that this may have been mitigated in the recruitment process when the participants were made aware of the topic being investigated beforehand. Every attempt during this process was made to take care and prioritise the voices of my participant's and was demonstrated all the way from the informed consent, pre debrief, interview, post debrief, and

during the analysis itself. I also kept in mind that my participants were considered to be co-researcher's in this study and therefore was mindful of adopting a non-hierarchal stance, which is consistent with my axiology personally and professionally.

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CHAPTER 3- ANALYSIS

Overview

This chapter aims to provide an account of the salient themes that have emerged from the interview data. Detailed analytic interpretations are offered, and transcript excerpts are presented in order to support the commentary. The themes have been organised to communicate to the reader a sense of the participants' subjective individual, and collective experiences, as well as the convergent and divergent aspects between them. Inclusion criteria for a particular theme include the presence of that theme in four or more participants. The themes have been organised without reference to any theoretical models to stay as 'close to the participant's experiences and views as possible' (Larkin et al, 2006). The interpretation of the data represents a co-construction between the participants' and the researcher, with a commitment to phenomenological and hermeneutic sensibilities. Fellow researcher consensus has been sought to aid in the interpretation process, ensuring that the researchers' own fore conceptions are bracketed off and not elevated, above that of the individual participants. This account will primarily focus on how nursing staff experience compassion within the context of an acute in-patient ward.

Two master themes were identified with five subthemes. The master themes are umbrella and interrelating parts of the participants experience. The corresponding subthemes offer a lens through which each master theme can be further deconstructed, offering detailed insights of the 'person in context' (Smith et al, 2009, p.17). The themes are represented below.

Key:

… Pauses in speech

[…] Omitted speech

Master Themes and Subthemes

Master Theme One: Perspectives of Compassion; the ideal

Putting myself in your shoes

Showing you I'm there – moving toward

Master Theme Two: The Conflict Within; inhibitors of compassion

Leaning away from you

Challenging emotions

Responsibility

In this section I will attempt to give a sense of the participant experiences of compassion and to show how the themes and subthemes that were found help to address the research question. Overall, experiences of compassion across all of the participants oscillated in terms of what compassion is in general, what they think it means, and how they experience it in their work.

In master theme one, *Perspectives of Compassion; the ideal,* participants offered their conceptualisations of compassion and the meaning it conferred to them. These perspectives appeared to take the form of what could be viewed as their ideal perspectives of compassion that may or may not occur in their working lives. In *Putting Myself in your Shoes,* I get an overriding sense that inpatient nurses experience compassion through understanding the cognitive, physical, or the emotional needs of their patients within the context of their daily working lives, and of what they think it might mean to be an inpatient. The following section aims to articulate impatient staff nurses' experiences of compassion.

Putting Myself in your Shoes

Five participants made reference to a mentalisation of the needs of others. For example: Natalie references:

> *Yes because I work in an inpatient ward…and sometimes…(they're) on section…and I kind of feel that…if you are not allowed to go out…in the mezzanine…I know what it is like…working in that kind of environment…it's like…you have been deprived of certain things…like maybe you want to get up in the morning and go out for a walk, but you are on section, you are in an environment where you cannot do it, and then you want to go and buy things that are in the shop that you cannot get on site[….](Natalie, 12)*

Natalie appears to be describing a reduction in the agency or autonomy for patients when she refers to '(they're) on section' and 'if you are not allowed to go out'. Although there is an implicit understanding of this, in terms of the nature of a forced detention in mental health; Natalie shifts the perspective toward herself, when she references 'I know what it is like…working in that kind of environment' and is perhaps letting me know that she is not a detached observer, but also putting herself in the shoes of her patients and portraying herself as very much part of the milieu of the ward. Linguistically, the phrase 'working in *that* kind of an environment' and another reference to the 'environment' further down in the excerpt, could be interpreted as Natalie eluding to the fact that the environment is a significant feature in her

experiencing and understandings of compassion. Natalie further references 'you have been deprived of certain things' and that 'you cannot do it' or 'you cannot get it' letting me know that how she has constructed what it means to be an inpatient. I wonder to what extent Natalie has identified with her patients experiences and integrated them in her own experiences of compassion. She further references:

> *[…] you might see a patient on the ward that reminds you of a family member that has gone through that…and then you feel like oh my god…this might be similar to my uncle […] (Natalie, 111)*

Natalie's reference above further illuminates this possible identification when she narrates that a patient may 'remind you of a family member' or 'this might be similar to my uncle', and thus pointing to a familial underpinning in her experiences of compassion in relation to her patients. I again wonder to what extent Natalie's perceptions of compassion are influenced by the close proximity she has with her patients due to her job role, that she is able to refer to them in kinship terms.

Like Natalie, Paul also references his idea of compassion as understanding the needs of patients and putting oneself in their shoes, of which he references twice in the excerpt below. For example:

> *Ok so personally compassion entails being empathic…putting yourself in the service users shoes…for example they come to you and say 'can I have a drink of water' …and you are like…no I am busy…you know…if you are a compassionate person and you put yourself in their shoes…they are probably on medication…medication has side effects…it does make them thirsty…cause dryness of the mouth…so erm if you are able to empathise with them…you say 'yeah sure lemme get you a glass of water'…I mean you may be in the middle of something…but I mean how long does it take to get a glass of water? I think compassion also entails listening…understanding…and I think above all caring…I think someone who has compassion has a caring nature […] (Paul, 3)*

Paul references 'being empathic' as well as 'putting yourself in the service users' shoes' as possible antecedents when explaining his understanding of compassion. He is also possibly implying a distinction between a compassionate and a non-compassion person when he references 'if you are a compassionate person' eluding to the idea that compassion may be something one possesses or doesn't possess, further illuminated at the end of excerpt when he

makes a reference to ‘caring nature’ again implying that he may experience compassion as innate or originating from within. In terms of the latter is Paul letting me know about the ideal compassionate scenario versus the reality when he references ‘no I am busy’ or ‘you may be in the middle of something’, and to what extent this may be out of his awareness. Paul also makes reference to compassion as the ‘listening’ and ‘understanding’ of another, further embedding that his lived experience of compassion is through the minds of others. When Paul says, ‘but I mean how long does it take to get a glass of water’, he could be suggesting that compassion could be demonstrated in small ways depending on the perspective of the staff nurse.

Mark also offers his perspective of compassion which echo some of the understandings from Natalie and Paul. For example:

> *It's kind of a hard one to want to put your finger on because compassion to one person might mean something different to another […] because I say oh nurses need to be compassionate but without describing what does that actually really mean, you know you hear on the news about that and they say nurses they are not compassionate and they are not really going to help; I think for me at the crunch of it is an understanding and being aware of other people's needs and that's how I think I'm going to try to find it and then having an appropriate response to that. If you were aware of somebody's needs and were then just ignore them, I would think that's not so much to me like I'm human. I suppose what I'm saying is that compassion seems to be a basic human trait, some people seem to have it more than others and yeah so, I don't think there's a hard and fast definition for it in my opinion anyway… (Mark, 4, 7)*

Mark references that he is unsure about what compassion may mean and refers to it as akin to something elusive or intangible when he refers to it a ‘it’s kind of a hard one to put your finger on’ and goes on to allude to it as being of a subjective entity to him, when he refers to compassion as ‘compassion to one person might mean something different to another’. Mark appears to be aware of the media representations surrounding nurses failing to espouse compassion towards patients when he references ‘because I say oh nurses need to be compassionate but without describing what does that actually really mean, you know you hear on the news about that and they say nurses they are not compassionate and they are not really going to help’ further highlighting that he experiences that meanings of compassion are not demarcated within the context of his work environment, and possibly contributing to his elusive

experiencing of the phenomenon. Mid way through the excerpt Mark lets me know the 'crunch' of his understandings of compassion which I infer to mean the core of his experience of compassion when he references it to be 'an understanding and being aware of other peoples' needs' thus echoing the mentalisation aspect of compassion cited by both Natalie and Paul above. Mark, like Paul makes reference to a possible movement away from an ideal compassionate scenario when he refers to 'If you were aware of somebody's needs and were then just ignore them, I would think that's not so much to me like I'm human'. The latter human aspect of compassion is again referenced by Mark when he refers to it 'as a basic human trait' and that 'some people have it more than others' solidifying his subjective stance about compassion as well as letting me know that he experiences compassion as being akin to being human.

Chris lets me know that he has similar understandings of compassion with respect to putting yourself in the shoes of patients and appears to understand compassion through attributes and capacities. He references:

> *One should have the ability and the willingness to listen…and when I say listen…I mean listen and show some understanding….as to what is coming from this other person […] one should have some understanding as to issues about this person… (Chris, 26)*

In the above excerpt, when Chris refers to 'ability and willingness to listen' when referencing compassion, which could be inferred as staff having the cognitive an emotional capacity, as well as the motivation to listen or help patients. Chris alludes to a lack of capacity further along in the interview when he references difficulties with staff engagement (290), and staff who may not be attuned to their patient's needs (298). Chris emphasises the significance of listening with respect to compassion, when he further reiterates 'and when I say listen… I mean listen and show some understanding'. He mentions the word 'understanding' twice, further illumination it as central feature in his understanding of compassion with reference towards patients.

Maya, like Natalie, makes reference to her kin relationships in her understandings of compassion. For example:

> *Basically I feel that, I think along the lines of how I would like to be treated, and whenever I encounter a situation, a patient, a person, I always think if I were in that position how I would like to be treated, if I was in that family's position what I would like my family to be treated like if my son, my daughter, my parents, auntie and uncle, if they were a place and needed care, how would I like them to be treated, and I think*

that sort of helps me, because I know, that I wouldn't want anyone that I was close to or anyone that I care about to be treated in a bad way, so therefore I wouldn't do that to somebody else...I wouldn't disrespect them, I wouldn't show them any harsh feelings, harsh words, I am firm but I am not cruel, I am assertive, but I am not aggressive, I have that balance, so I think that's how I stand with how I treat people, it all stems from how I would like to be…treated if I was in that position ..(Maya, 12)

Maya appears to be putting herself in the shoes of patients via comparing patient needs to that of how she 'would like to be treated'. In the narration above she adopts the position of a family member of a patient and references it to possibly being akin to her own family when she explains 'if I was in that family's position what I would like my family to be treated like if my son, my daughter, my parents, auntie and uncle, if they were in a place and needed care'. This familial element relating to others seems to originate from her upbringing when she references later on in the interview that her father helped strangers out of poverty (32-35), and that she liked this aspect about him (39), and I get the sense from this that being compassionate towards patients is part of both of her personal and professional identity. By default, it appears as if Maya is letting me know about the instances of a lack of compassion on the ward. She references a desire of not wanting her family to be 'treated in a bad way' with 'harsh feelings' or 'harsh words'. She tells me she's 'not cruel' or 'aggressive' giving me the sense that her observations in her job role are incongruous with her own identity and that of her understanding and experiences of compassion and could be indicative of underlying difficult feelings for her.

In the next section inpatient staff nurses understand compassion through action, i.e., practical acts of care, almost akin to an offering of oneself in order to demonstrate compassion towards their patients, which could facilitate compassionate care. I will attempt in the next section articulate some of the ways in which they have put this across.

Showing you I'm there

Six participants made reference to demonstrative acts of care which were either behavioural or emotional. The subtheme of *Putting Myself in your Shoes* was often the precursor to *Showing you I'm there and* was deemed to be meaningful to inpatient nurses' experiences of compassion.

[…]also compassion like I said can happen in a one to one situation where you are just having a chat with somebody, and another good time is when you are waking people up in the morning…they don't like to be shouted at...doors banged…you know get up,

people want to be spoken to…first thing in the morning you want a nice tone of voice…quiet…respectful…it can be so many things like if someone knocks on the office door requesting something and rather than just ignoring them and saying 5 minutes or just 2 minutes…just respectfully answer them and say like what do you need and ok I will get that for you now…and if you can't do it now just say I'm just very busy just give me two minutes and I will be out and I will do it…I think yeah…those are the sorts of tangible elements of compassion working day to day[…](John, 106)

John references acts of compassion being demonstrated in his day-to-day job role, and I get the sense that it's part of his newly formed professional identity which he referenced earlier in the interview as having recently graduated (53) and having enthusiasm and passion for his job (54) and is meaningful to him. John appears to be letting me know how compassion can be demonstrated by referencing the use of 'a nice tone of voice' whilst interacting with patients that is 'quite' and 'respectful' as part of his narrative. Contrastingly, he references that patients 'don't like being shouted at or doors banged' and also references being told to 'get up' (accentuated). I wonder if John is referencing acts of uncompassionate behaviours that he has personally experienced, and I wonder to what extent it has influenced him as a person and as a newly qualified staff nurse, of which he alludes to when he lets me know that staff members who have been there for a longer duration (30 years) (55) and are 'disenchanted' with the job (56). John also references 'tangible elements of compassion' potentially illuminating to something that is visible by another.

Natalie also references showing compassion to her patients. For example:

[…] I would go out of my way sometimes and go out and get for them… because I know how important this thing is for them… It can even be ordinary things… like sweets...a bar of chocolate... and it can even be newspapers and things like that…. I will actually go out of my way… to… you know... Sometimes I would go even in my break time… to go and do this…. knowing that this would make them happy…and that this would even make them understand that they are not just patients...and that they are human beings… and that they have listened to and heard... (Natalie, 15)

Natalie references 'going out of my way' for patients, indicating that this may be originating from her own agency and how she experiences compassion. She reiterates this again where she emphases 'I will actually go out of my way', and 'sometimes I would even go in my breaktime' inferring an altruistic quality to her experience of showing compassion. She also gives practical

examples of how she shows compassion toward her patients such a ‘going for a walk’ and getting ‘newspapers’ or ‘a bar of chocolate’. Natalie speaks with conviction when she tells me she imparts how she has constructed that her intervention is possibly contributing to a shared understanding between her and that of her patients of ‘knowing this would make them happy’ which may have echoes of prosocial behaviour. This helping behaviour is again reiterated when she refers to this action as having an effect in the psyche of another, in that it ‘would even make them understand that they are not just patients…and that they are human beings. She references ‘they have been listened to and heard’ demonstrating that her experiences of compassion go beyond just the demonstrative acts and toward wanting it understood by patients. I wonder to what extent Natalie is letting me know that there may be some instances when she feels that patients may not be treated as human beings and her feelings about it, and also to what extent this has influenced her actions of going out of her way as referenced above.

Paul, like John and Natalie makes reference to demonstrative aspects of compassion as to what he understands compassion to mean. Paul explains:

> *A central theme is on medication…a lot of the time the patients say “this medication…it doesn’t work for me” “I used to be on a different medication” …” why did they change my medication” …” could you maybe speak on my behalf” which I have always tried to do…. because what I normally do say is alright “if this medication is not working for you...what has worked in the past? “…. because you have to find out…you know how informed they are…because you know they say actually when I was on risperidone you know I was a lot better…I was doing well……a number of times this has essentially being taken on board by the MDT…I mean that is one area where patients feel that they are essentially not listened to… (Paul, 27)*

Paul appears to be referencing a compassionate mentality when refers to patients being on the wrong medication and references it as an area where patients feel that they are not ‘listened to’. Paul, like Natalie appears to be using his own agency in advocating on behalf of his patients when he says, ‘because you have to find out’ and seems to be emphasising its importance and meaning to him. This is reiterated when he references ‘which I have always tried to do’ when advocating for his patients. Paul appears to be making a proactive choice to show acts of compassion towards as he understands it towards his patients. He also refers to taking steps to relay this information back to the MDT team in an attempt to provide a medium for patient’s voices, and thus making them feel ‘listened to’. This can be further supported further along in

the interview when Paul references 'here you actually go out of your way to resolve things (41), when referring to advocating for a change in the menu for a patient.

Ingrid also references what can be constructed as showing compassion. Ingrid explains:

> *[…] just if someone wants to go out…a load of erm want to go out for a walk…then you just take them out….so do'ya see what I mean…you know you do show them compassion […] (Ingrid,126)*

She appears to reference paying attention to the agency of a patient, in that if someone 'wants' to do something then she 'just takes them'. Ingrid appeared detached in the interview, and toward the end of the interview, she releveled that she had been impacted by a friend/colleague having been beaten up on the ward (562-572). I wondered to what extent Ingrid was able to show compassion to the patients in light of this. This is picked up again in the following theme of *Leaning away from you.*

Maya echo's this demonstrative act of compassion further. She references:

> *I think it's being kind and showing your kindness. For some people it's like ok I am here to work, and I can only do so much and so that's where your kindness ends, or you can take that extra step to show that you…can…and genuinely care (Maya, 65).*

Maya appears to be referencing that compassion for her is not just about a job role when she narrates 'ok I am here to work' and that she feels that it is beyond that and is a 'kindness' and a 'showing' of that kindness in a 'genuine' way and it being demonstrated proactively when referencing 'take that extra step'. Maya seems to be interested in possibly letting me know that compassion is a way of life for her and a conscious choice as part of her identity and that of her identity in her job as a nurse. Maya appears to be letting me know that compassion for her has an authentic quality to it, which is reiterated by Natalie when she refers to a compassionate person as 'genuinely caring (33).

Chris, when referring to showing compassion references:

> *[…] One should show empathy…one should…and I know I have said this…but that would be communication skills…and that would be repetitive […]*

Chris refers to 'showing empathy' as a means of how he experiences compassion toward patients, and emphasis that 'one should show empathy'. He refers to 'should' one more time, and I wonder to what extent this may not be occurring. He appears to be letting me know that showing compassion may be via 'communication skills' that could or ought to be a continual process by the use of the term 'repetitive'. Through non-identifiable factors Chris is a senior

member of staff, and I wonder when Chris narrates 'and I know I have said this' to what extent he feels like he had been repetitive in his job role, and to what extent he feels that he has been heard. This interpretation could be given weight towards the end of the interview when he says, 'and you would not believe that this a well has been some sort of a supervision for me' and 'it has enabled be to really pour out'.

Master Theme Two: The Conflict Within; inhibitors of compassion

This section illuminates internal challenges that can occur for staff within their job role and represents a dichotomy between an ideal compassionate self and one that could be inferred as a movement away from it as is shown in the context of an acute inpatient ward as contextualised as *The Conflict Within, inhibitors of compassion.* In *leaning away from you* I attempt to impart how staff nurses can compartmentalise compassionate mentalities, either physically or emotionally and distance themselves from patients. In *Challenging Emotions,* I unpick some of the difficult emotions that staff members experience internally and as part of the wider team dynamic. In *responsibility* I impart how it can play a role in staff members feeling unable to express compassion in the way that they would like to.

Participants appeared to identify difficulties in engaging with patients, which were seen as hindering compassionate responses. This has been conceptualised as *leaning away from you.* Five participants described aspects of this, which appeared to be experienced in cognitive, emotional and behavioural terms. John, and Maya, describe behavioural acts of leaning away from patients through aspects of restricting interaction or restricting compassion towards patients. They appeared to do this in various ways. John describes the use of 'boundary language' which appeared to be a means to communicate to patients, a desire to *lean away* from them. He described the use of voice intonation, used in 'abrupt' and 'direct' ways used in hierarchical communication in what could be conceptualised as a reduction in agency or autonomy toward patients, in which he references as 'it is this way or no way'. Additionally, John describes observable aspects of what he describes as staff not appearing to understand when a patient is upset or distressed; and that they are not empathically attuned with the mental health needs of their patients; and that they have a somewhat rejecting quality to them or seen to radiate a 'cold element'. Maya describes observations of similar proximity reducing behaviours, which appeared to include acts such as physically moving away or avoiding eye contact with patients, with accompanying stigmatising judgments toward them. Natalie

reiterates this in describing the use of negative comments when staff refer to patients. Both of these appear to precede corresponding distancing behaviours involved in a lack of compassionate responding. This will be further detailed below.

Leaning Away from You

John makes reference to what he calls a 'restrictive interaction' described in the excerpt below:

> *Yeah…they will just use sort of boundary language…you know… so there is no options being offered to that person…it is this way or no way…the intonation…the tone of voice is very you know...abrupt…and direct…and umm….yeah…[long pause] it's just kind of restricting interaction that they have…and that's what…[pause]…there doesn't appear to be that understanding…you know…they can't seem to understand that… you know…that that person is obviously really upset or distressed...and they are now in a position where they are going to be restrained…there are times when you just have to go in and be quick because there are no options and there's a danger…erm…but when that danger is not there…there are still options…some staff are very kind of quick to go look this is what's gonna happen…you either do it or you don't…right…well…it doesn't have to be so quick…* (John, 152)

John appears to be communicating a forced or coerced reduction in the agency and/or autonomy of a patient when he describes 'it is this way or no way' or when referencing staff as 'restricting interaction' whilst using 'tone of voice' and 'intonation' in an 'abrupt' and 'direct' way. His pauses (155, 157) could indicate his uncomfortable feelings in trying to make sense of his observations. I wonder if he had voiced these thoughts and feelings outwardly before as he deconstructs his thoughts to me and says, 'there doesn't appear to be that understanding' and that 'they (staff) can't seem to understand'. John appears to be referencing a lack of mentalisation that he has observed radiating from his colleagues towards patients with mental health difficulties. He references the feelings of 'distress' and 'upset' of the patients, as experiences seemingly not being integrated into the mental health discourses of the staff attending to them (156), thus possibly indicating patients are not seen in their entirety as individuals but as parts of the mental health system or a task or as a job to be attended to as they are 'going to be restrained'. John also describes staff responses to perceived 'danger' as being 'quick' or reflexive, again appearing to reference a detached state of being away from patients. In a sense John may be is describing his own parallel processes of feeling helplessness at not being able to influence his colleagues' interactions with patients

when referencing ‘it doesn’t have to be so quick’. This can be summed up when John further highlights his lack of confidence in his colleagues whom he describes as generally being quite cold (144, 145). This may infer and support the idea of splits occurring within the team with variable degrees of compassionate care being delivered and therefore further highlighting the lack of emotional presence in some staff, which is further discussed in the next section.
Further along in the interview, John tells me his thoughts regarding how he has made sense about the cold (145) nature he has observed in some staff toward patients. John explains:

> *[...] there are a culture of nurses that can’t empathise and can’t understand….cause in their own country that kind of behaviour would never ever be tolerated…and the way that they do things would be very different than this country…so you’ve got someone that has an eating disorder for example and erm …they don’t or they can’t empathise with that…or understand…or show compassion to that because that’s just food…like what’s the problem…you know…so culturally the backgrounds that they come from…to understand the wide spectrum of illness that we deal with…I find that there is a very sort of cold element there….and that’s not the case across everybody… there are some staff there…but generally that’s what I find…(John, 177-185)*

John appears to be describing a scenario referencing non-indigenous staff (173-174) as not being able to ‘understand’ or show ‘compassion’ to the ‘wide range’ of illnesses (mental) presented on a ward. As a non-indigenous researcher, I consider how John views me as a researcher whist talking about race, as he hesitated (174) during his description. He proceeded to tell me that he had had concerns about his own awareness (176) about this issue and had sought consensus from other staff (175, 204), and I wondered if taking about race and culture brought up some uncomfortable feelings for him. I got a sense that on some level he was aware of his possible biases, but not aware that he had assigned them solely to a particular group of people (174), therefore unable to see individual differences, or broader relationships of compassion and culture in behaviour. It’s sensible to err on the side of caution when interpreting fertile references to race, however what seems to be apparent is that culture and compassion seem to be linked as part of John’s experiencing of compassion on the ward. John gives a specific example of staff referencing ‘eating disorder’ and infers a particular culture may not consider it a part of a mental health discourse, which could minimise instances of compassion shown, and cause staff to lean away. This could be further grounded when John makes reference to ‘boundary language' and a ’cold element’ radiating from staff, and ‘they don’t, or they can’t

empathise with that…or understand…or show compassion to that because that's just food'. I wonder to what extent this experiencing has brought up difficult feelings for John, when he further references when prompted 'it's sad really…'it's sad'.

Mark, like John also references aspects to 'restricting compassion' and therefore leaning away. He references:

> *[…] I think everybody probably has got some compassion, but they can somehow restrict it all. I kind of thing people can sometimes box their feelings off as a self-defence sort of mechanism. They can see what's happening to that person is really terrible and say I really want to go and help, but I know I haven't got the time or be I don't know if I can cope with it because I've got enough problems of myself and I think that's me that something that someone might say I've got enough problems I can't possibly cope with all of their problems well they can sometimes also put a barrier up and I think we'll can do it to a certain extent I am sure I have done it and then you say something anything or you know I don't know I do hope with that at the moment I can see that persons in distress but you know what I'm just going to hand it over to somebody else because I can't cope with at the moment, I got something else to do so I'm sorry, I guess we all do it to a degree(Mark,51)*

Mark tells me that he is newly qualified (66) and due to other non-identifiable factors, I conclude that he has come into the nursing profession later on in life and draws a sense of pride from his role. I find instances in the interview where I get a sense that there is a mismatch between the realities of his job role and that of the expectations he held whilst he was a student (24-25, 66-73), and therefore he may be speaking from an autobiographical perspective. He references a 'restrict(ing)' and a 'box(ing)' off of feelings as a 'self-defence sort of mechanism' when speaking rhetorically. I wondered if in his use of 'sort of' he was trying to align his own feelings of possibly restricting or boxing off his feelings in order to complete his administrative (72-73) tasks. He switches from 'they' to 'I' when referencing 'they can see what's happening to that person' to 'I really want to go and help' thus possibly indicating his inner conflict. Towards the end of the excerpt, he references 'I've got enough problems' and 'I can't possibly cope' and 'put up a barrier' again possibly letting me know how difficult he is finding things.

Maya also makes reference of what resembles staff nurses leaning away, from compassion. I get the impressing that Maya feels pressed to let me know about what she sees as a lack of

compassion on the ward. Maya sums up a situation of which appears to be a non-verbal demonstration of non-compassionate behaviours.

> *[...]even other staff would move away from her from where she is eating, and be grossed out by her, and genuinely disgusted by her, and they were not even able to be professional and just say like I can't stand the way she is being treated and stuff.* (Maya, 77)

Maya uses what appears to be using forbidding language when she attempts to tell me that staff members were 'disgusted' and 'grossed out' by a particular patient, and that they would 'move away from her'. She referenced that this had been at a previous job (69), and I wondered to what extent this had made an impact on Maya, and to what extent these feelings were still alive for her. She appeared to be reliving these emotions when she articulated 'I can't stand the way she (patient) is being treated and stuff'. I also get a sense from Maya that when articulating 'they' while describing her colleagues lack of professionalism (79) to me, she was describing a sense of isolation away from her colleagues and found these behaviours inexplicable to her. She further references:

> *[...] you have families, you have friends, you should think about how that person feels when you don't interact with them or pass them and you don't say hello to them because they are smelly and you show them that they are gross looking […] (*Maya, 125)

It appears that Maya is observing a lack of mentalisation and detachment in her colleagues when she references a lack of observation about how a person would 'think' or 'feel'. It appears that she observes that patients can be dehumanised by other colleagues when she references 'you don't interact' and 'you don't say hello', again referencing a form of possible dehumanisation or rejection having radiated from certain colleagues, which appear to be diametrically opposite to compassionate behaviours. Further along in the interview Maya references:

> *[…] they were disgusted by seeing this big person who was continually eating, and it's like they forgot that there is a diagnosis […] (Maya, 83-84)*

In articulating 'it's like they forgot' it appears that this may have been a point of rumination for Maya, and something she had tried to make sense of. This inference can be grounded further in the next two quotes:

> *[…] I don't know my colleagues' circumstances […] (Maya, 268)*
>
> *[…] for all I know they are having a harder time than some of the patients […] (Maya, 269-270)*

I wonder if she is describing her own parallel processes of feeling cut off from her colleagues in trying to make sense of what she is seeing. She also draws parallels between staff and patients when she references that they may be 'having a harder time that some of the patients', inferring possible psychological problems being experienced by staff.

Natalie also shares her experience of what also can be inferred as staff leaning away:

> *[…] and there are some comments that you might hear that will shock you like…. there is nothing wrong with them… and when people come on the ward and that there is no fixed abode and that…. they say he is only looking for housing… he doesn't really need…. I don't think that there is anything wrong with him…. they never explore what's actually wrong …but tend to be judgemental… (Natalie, 119)*

I experienced Natalie as very keen to participate in the interview and came across as relatable. When the audio recording of the interview started, she appeared to close up. I wondered if she was feeling unsafe or entirely trusted the process in order to commit her views onto recorded media. Natalie referenced her colleagues as making 'comments' that would 'shock you' which appeared to have a negative or pejorative connotation. I wondered if Natalie was trying to tell me about her own shock of hearing these comments and I wondered if she was censoring the worst of them from me, as was demonstrated by her tentative demeanour. She gave examples about staff members questioning mental health diagnoses of patients by saying 'there is nothing wrong with them' which she repeated further along in the excerpt with 'I don't think that there is anything wrong with them' which indicated a possible prevalence of diagnoses not being believed or questioned by staff. Natalie referenced 'looking for housing' cited by her colleagues as being a hidden agenda as to the possible motives for admission to the wards, thus giving an indication that staff may have become desensitised mental health difficulties of patients. Natalie references what could be construed as a movement away from patients in referencing 'they never explore what's actually wrong' and further illuminates that in her view, that staff are 'judgemental' towards patients. Natalie appears to be letting me know that these are some instances of a lack of compassion, and when prompted she references that 'the majority of staff are compassionate' (135), I wonder to what extent these instances have impacted Natalie's' feelings towards her colleagues.

Ingrid also makes reference to staff leaning away emotionally. She references:

> *[…] well… because they are not compassionate basically… because they are not there… I don't know… I don't know what goes on in some people (Ingrid, 384)*

In the above quote, Ingrid references staff as 'not compassionate,' and infers it's 'because they are not there'. Ingrid appears to be letting me know how she has constructed this when she says I don't know what goes on in some people. Earlier on in interview she references the use of phones whilst staff are conducting observations (378–379), appearing to observe colleagues as distracted or leaning away from patients.

Paul also makes reference to non-compassionate ways of relating to patients which could also be inferred as leaning away.

> *[…] to be honest it's quite a stressful environment… not always, but…. It can be used quite stressful and... sometimes the way people cope is to sometimes… you know people's character differences… some people have a temper… some people are just lazy…. and all this is true…. some people just don't really care…. which is true…and I have seen it a lot of times… but of course not everybody is singing from the same hymn book… you know everyone has a different status of you know relating to patients (Paul, 70)*

Paul refers to the ward context as a stressful environment. He appears to be referencing emotionally distancing behaviours by staff. He refers to the ways in which 'people cope' and references 'some people have a temper' or that 'some people don't care' or that 'some people are lazy' which could collectively be constructed as a reaction to the ward environment. Paul, like Ingrid, offer their experiences of what hinders compassion. I wonder to what extent Paul is describing his own parallel processes of how he may cope with being in what he has referenced as a stressful environment. The next section also follows on from the theme *The Conflict Within, inhibitors of compassion* and attempts to articulate the participant experiences of difficult emotions as playing a part in hindering compassionate care towards patients.

Difficult Emotions

Four participants illuminate experiencing difficult emotions, which are deemed to be inhibitors of compassion.

Paul talks about his experiences of being at the receiving end of sexually threatening behaviour from a male patient. I experience Paul trying to cognitively make sense of this experience in light of the patient being 'unwell' (167) and I observe him trying to rationalise the behaviour of this patient in line when he says, 'unfortunately it is my turn' (167), but it appears to me that this experience is has brought up difficult feelings for Paul because the attention was from a man. Paul explains:

[…] I feel very uncomfortable being out there…. you don't want to go into his room or anything like that.... I do feel that I should hand it over… But I totally keep my distance… I don't really want to engage with them unless I really have to… and I remember when I had to do the rounds…I had to ask somebody to go with me… There was no way I was doing a depot… I made it clear… (laughter)… (Paul, 167)

Paul appears to be describing fear and avoidance towards a patient. I wonder to what extent he has been trying to minimise these feelings by what I perceived to be his uncomfortable laughter at the end this narrative, using humour to play down his fear. Feeling afraid could be further grounded by Paul asking somebody to accompany him while he did his wards rounds and referenced that he 'did not feel comfortable'. Experiences of compassion appear to be present when Paul keeps in mind that the patient is 'unwell' but mostly omitted from the narrative in this instance, possibly indicating that when there are challenging emotions that compassion is minimised when someone is feeling threatened.

…I did consider cancelling my shifts if it continued… as I did not feel comfortable at all… (G, 178)

John also makes reference to strong emotions when he talks about some of the relational difficulties he has experienced. He references:

*[…] the other side of being racially attacked is when its um **malicious** and there is an undercurrent of it…its more silent and its more **conniving** and that I think is when it really hurts…when a patient will talk behind a nurse their back to like another nurse or erm accuse them of things that they haven't done or bad practice…and actually it turns out that they are being racist for example...that obviously will be a heck of a lot worse that being shouted at directly (John, 235)*

John appears to be making sense of being talked about 'being' his 'back' and perceives it to be insidious calling it 'conniving' and 'malicious'. He makes reference to what he cites as racist taunts as being a lesser evil to being shouted out, alluding to how emotionally difficult me may find it. He further references difficult emotions with reference to task demands.

[…] like I've got to do a care plan with someone before 4o'clock and I've told this person for the last two days that I will be doing it today …and its extremely frustrating because I'm having to do all of my other jobs…and go to ward round for example…like I said to you… you have a whole list of jobs to do…and if I don't get it done tomorrow

they will say {name} why didn't this happen or why wasn't that done blah blah blah…so it's difficult (John,299)

John references being routinely held to account by a first name basis in a ward round 'they will say John, why didn't this happen or why wasn't that done' and of his feelings of it 'being difficult' or of the deep strain he may feel when referencing 'it's extremely frustrating'. I get the sense from this that John finds all of the tasks overwhelming, and he is operating on a moment-to-moment basis when referencing '4o'clock'. He appears to be referencing consequences in 'if I don't get it done' thus giving the impression that he is working to avoid being singled out.

Chris also makes reference to difficult emotions: For example:

[…] more often than not and by my own crude study and my own observation…they do get consumed in their own…pause…. I would say emotions too intense…as if there is an arousal…so yeah…they don't offer themselves the opportunity to really reflect as to ummm…my response to this person…what it good? Was it helpful? Or otherwise…so more often than not…you find out that the emotional response to the professional is when they patients' response to not being listened to…is seen as the other side of the pool…do you get what I mean? Where the patient becomes angry…abusive…to the degree of being physically what can I say aggressive… (Chris, 74-81)

Chris appears to be referencing staff as having all-encompassing emotions by using the language 'consumed' and 'emotions too intense' and 'arousal', suggestive that he experiences this a physiological response. He also alludes to a lack of mentalisation when he references that they don't 'reflect'. He uses the phrase that they 'don't offer themselves the opportunity to reflect' implying that it is a conscious choice and within their control. I wonder what feelings this may bring up for Chris as he has a senior role on the ward. I got the sense from this that Chris was not only viewing staff as not being emotionally present for patients, but that he was a detached observer himself as he didn't view staff from a position of compassion or empathy. He also eluded that patients 'emotional response' can be trigged by staff and in them not 'being listened to', and references instances of 'anger', 'abusive' and 'aggressive behaviours'. I wonder if Chris had the need to feel understood by me when he referenced 'do you get what I mean?', and I wonder to what extent he may have been trying to let me know that experiencing intense emotions may not be compatible with compassionate behaviours.

Ingrid displayed to what appeared strong emotions during the course of the interview. However, toward the end of the interview I came to the realisation that Ingrid might have been feeling unsafe in general. Various data points toward the end of the interview pointed to unfamiliar staff of being of some relevance to Ingrid's experiencing (F 214, 218, 220, 223, 234). Ingrid described a member of staff who had been violently beaten on the ward and that she had seen the facial injuries of her colleague (a friend) after the event. Ingrid attributed the attack the failure of an agency staff on duty that had left the victim alone with a patient to go for a toilet break, thus contributing to Ingrid's deep mistrust of agency staff. I experienced Ingrid to be psychologically affected by this incidence as she was tearful toward the end of the interview whilst describing the violent attack. This mistrust appeared to now be directed toward patients as a result of this experience. Ingrid explains:

> *umm I dunno really….yeahhhhh ….we're more…before….[long sigh] dunno I think staff are more wary…staff are more…I wouldn't say frightened but it's weird…it awkward how to…they are more worried…don't know how to explain it really…but there is definitely something there…you sort of…when a patient comes in you don't go…you sort of…we didn't know that patient at all…they are the ones….because the ones we do know we can go by their previous risk and what they do…when somebody new….there is nothing to go by so you don't know….I mean that boy had never done anything like that…there was no history so there was none anyway…but um [long sigh]…and with that patient who came in with all them police at the weekend….you go no…if you can't manage them then they shouldn't be on this ward….i think we are being a bit more assertive I think...whereas before it was like oh you know we'll give him an obbs….now they are a bit more like no we are not gonna….we are not going to have that risk on our ward …you know cause of what happened to ***** (Ingrid 608).*

Ingrid appears to be struggling with her thought processes of what she is attempting to tell me, as she pauses and lets out a long sigh (610). She appears to be articulating herself as a changed person or having been through something and also references this as part of a collective narrative of experiencing on the ward. She references being 'wary' and 'frightened' but that she hadn't possibly integrated this experience yet by the use of the terms 'weird' and 'awkward'. She seems to be using the interview to let me know the change in her experiencing or identity as a nurse when she tells me 'there is definitely something there', again letting me know she hasn't fully processed the incident. She tells me 'we didn't know the patient at all'

possibly indicating what may have felt uncertain at the time when she struggled to make sense of the incident in 'there is nothing to go by' and 'there was no history'. She then switches to the present tense when telling me about the weekend and her newfound vigilance or 'assertiveness' when telling me about a patient being escorted by police and her saying 'you go no' referring to a new change in style. Ingrid appears to be letting me know of a new attitudinal stance when referencing 'we are not going to have risk on the ward'. Ingrid also makes reference to staffs being 'wary now' and that' you never know' after an incident of violence on the ward, possibly indicating *not knowing,* or that interaction with new staff, or new patients are possible antecedents for difficult emotions and contribute to her feeling unsafe. These feelings of unsafety are can be further grounded below when Ingrid goes proceeds to describe in detail her processing of the details of the attack on her friend. She references:

> *yeah…she err… she was on a night shift and erm [pause] she was doing level 3 observations with a patient and erm agency staff was doing level 3 observation's with her on another patient…same corridor…and um the agency staff got up and said I'm going to the toilet and just walked off and left her there…the patient that he was doing a level 3 with came out of the room….and ****** said to him and bearing in mind that ******* was a 50 years odd woman…she was sitting in the chair and she went that you need to go back into your room and he just punched her face right there…beat her …terrible….terrible…I've never seen anyone with such injuries as what happened to her (Ingrid,562)*

Ingrid appears to be letting me know that although she did not directly witness the attack, she felt emotionally impacted by what had happened. I wonder to what extent having seen her friend's injuries had impacted her emotionally when she references 'terrible' twice and 'I've never seen anyone with such injuries as what happened to her' indicating difficult emotions and her disbelief about the incident. Ingrid also may have feelings of vulnerability and may identify with the victim as a woman, and a peer of a similar age (569). Ingrid further references:

> *[…] he could have killed her…. a little bit longer and he could have killed her…her whole face was just black and blue…he broke her arm in two places…absolutely awful it was mmmm you know…we've had all that to deal with as well… (Ingrid, 583)*

She alludes to possible ruminations about the incident and is possibly letting me know that it is still alive for her when she references 'he could have killed her…a little bit longer and he could have killed her'. She may also be alluding to the whole nursing team on the ward as all having

been impacted by the incident she says, ‘we’ve had to deal with that as well’. She also imparts to me her fears for herself and lets me know that she feels that no one will come to her aid, almost describing difficult emotions possibility relating to fear. Ingrid explains:

> *[…] It kind makes you feel…I mean what happened to ****** was terrible do’ya know what I mean [wanting to be understood] but you feel now that even if I got a punch in the face or something the police aren’t gona take it anywhere…and then they go to you oh phone the police and report it…you know if someone can do that to you and…. (Ingrid, 577)*

In the next section I attempt to article the participant nurses’ experiences of feeling responsible in their job roles which appear to contribute to hindering compassion.

Responsibility, the buck stops with me

Four participants make inference to responsibility (or a lack of it) to be inhibitors of compassion. Natalie makes reference to this below:

> *[…] we are talking about… support workers… they don't act as if they have a sense of responsibility for the team… I don't think that they have enough knowledge of what they are doing…. I think that they are doing it because…. maybe… okay…. I didn't get that job… I got this job... so I am not accountable... whereas if you had gone to university for three years to study, you would have known what empathy and compassion all is about.... you would have the years to change your mind or say this is what I want… theoretical knowledge does help as well in understanding mental illness… because people think… for example…. If you have a patient on the ward who wets themselves…. I'm sure they don't want to have incontinence of urine…. Is due to their illness…. and at that time when they need help…. and you attend to their personal care…. and then 30 min later they do it again…. and then you say to your support worker…. please do you mind changing this person? and then he goes, Oh my God…. you know the attitude they bring forward…. and the response you get makes you feel mmmmmm are you just doing this job because I need a job…. (Natalie, 83)*

Natalie appears to be telling me how she has made sense of how she has appraised support workers. She references a lack of ‘responsibility’, ‘knowledge’ and ‘accountability’ in her narrative. The language can be interpreted as possibly scolding and letting me know about her frustrations or animosity toward support workers about what she deemed as uncompassionate behaviours. I wonder if she is telling me that she experiences this as a burden upon her and a

strain on her resources. She references a less educated worker as lacking in compassion when she aligns 'theoretical knowledge' as well as 'going to university' as prerequisites for 'empathy' and for 'understanding mental illness'. She references staff having an 'attitude' and lets me know that she feels that this is due to the fact that 'I didn't get that job' and that 'I got this job' thus possibly constructing staff as detached.

Mark alludes to how he has constructed his responsibilities in his personal and professional life. For example:

> *[…] as nurse as we all have home lives as well and managers and patients can sometimes think life totally revolves around the ward and that's it, but I have bills to pay I have a mortgage, I have a wife, I have three children who all expect me to be there for them as well. Sometimes this conflict…and sometimes if you have a bad day at work, and sometimes I do bring it home with me which is wrong… (Mark, 33)*

I get the sense that Mark may be feeling not seen in his entirety when he says, 'managers and patients can sometimes think life totally revolves around the ward'. He references his financial commitments and that his wife and children 'expect me to be there'. I sense a deep sense of sadness originating from Mark when he says 'sometimes this conflicts'. He references a 'bad day at work' and that 'sometimes I do bring it home with me which is wrong'. Mark has a long pause after is says the word 'wrong' and I wonder if he has said this out loud for the first time, and to what extent in this may be contributing to is ability to cope referenced earlier (56), and to what extent these feelings may inhibit compassion.

Ingrid refers to a lack of responsibility by agency staff: For example:

> *[…]I'm not saying it's all agency staff….but some agency staff are just there to earn their money …you see what I mean…they've not…they are not a full time member of staff …they have got responsibility…but not like us if you know what I mean…to the patient…so I don't think they show much compassion to the patient…you do get some good ones though….i'm not saying they're all bad so…dunno maybe I shouldn't be saying this…so yeah…they are not going to so as much compassion as …they are a lot of patients that we know for a lot of years… (Ingrid, 217)*

Ingrid makes reference to agency staff, or unfamiliar staff as being less compassionate 'I don't think they show much compassion' and like Natalie, cites 'earn their money' as being a reason as to why they are not compassionate in her view. She appears to be making reference to a them vs us mentality when she references 'but not like us if you know what I mean' which can be

interpreted as making a distinction between group members. I wonder to what extent new staff or agency staffs pick up on this group dynamic and to what extent it may cause a lack of integration in the team, and to what extent this has the effect of influencing their ability to be compassionate. Ingrid seems to be viewing agency staff with scepticism, and I wonder to what extent she experiences them as untrustworthy, having referenced her feelings about the attack described above. Ingrid further references:

> *[…] yeah…staff just say you know…like I said their work load is just bigger you know because …and I feel as well…I was talking to a member of staff today actually and he said what he don't like about it is that he say that that's he's actually responsible for them staff that he doesn't know them…do'ya know what I mean…just say these are agency staff and if we like don't know them….and I suppose he's right in a way when he says your responsible then….you are not only responsible for the patients…you are responsible for them three members of staff or whatever…you don't even know…how they work….what they are like…which is true …it's difficult isn't it…(Ingrid, 310)*

Ingrid appears to be referencing a sense of burden experienced by full time staff in terms of 'workload' and 'responsibly' for agency staff which she references three times in the above excerpt indicating its significance to her. She refers to a conversation with another staff member and reiterates that 'we don't know them' (agency staff), and possibly inferring that unfamiliar staff can't be relied upon, and again possibly making a them vs us distinction. I wonder to what extent this distinction can influence prosocial behaviours and compassion. She further references 'it's difficult isn't it' and 'you don't even know…how they work' and 'what they are like' possibly wanting me to validate her feelings. I wonder to what degree may be displaying avoidance and safety behaviours towards staff/ and or patients as a result of her experience to help her to feel safe, and to what extent it hinders her ability to be compassionate. This idea can be further grounded in the excerpt below:

> *[…] you do worry about the patients don't ya…because I mean…I don't know…yeah you do worry about them…cause you don't know these people do ya…and you do hear things don't ya…(Ingrid 322)*

Maya references responsibility in terms of task demands: For example:

[…] It was frustrating…ideally I like… if a patient asks me something I like to say I will be there in five minutes…or I can't…I can't give you a time but I will do it soon…and if I can't do it I didn't like that…like often I found that I never finished work on time there because I like to

get things done, and I like to get things done myself because there aren't any repercussions …if anyone says the work isn't getting done if it was my responsibility…I wanted to get it done… (Maya, 413)

Maya lets me know that she feels it's 'frustrating' when she is unable to meet requests of her patients, and that she 'didn't like that'. I experience Maya to be morally conflicted, as it appears that her ethos of care is to prioritise patient needs above that of administrative tasks. She references 'my responsibility' and 'repercussions', somewhat implying a punitive aspect to her experiencing in her job role, and I wonder to what extent she feels the need to avoid this. Earlier in the interview she refers to a time when she experienced her manager telling her off in a 'sort of mother to child telling you off in public' (330), and I wonder if feelings of responsibly translate to avoiding what she may experience as hierarchical criticism, and to what extent this influences compassion. This can be further grounded in the excerpt below when she references 'especially if my name is on it' in response to enquiries made my doctors in ward rounds.

> *[…] I don't wana say that…or sit in a room…when you go to a ward round and the doctor is saying …yes is this done? Or is that done? Especially if my name was on it…why wasn't it done… (Maya, 423)*

CHAPTER 4 – DISCUSSION

Summary

In this chapter, after re-stating my research aims, I will use existing literature to review and examine *perspectives of compassion,* and *the conflict within* – the master themes that emerged from the analysis of the participant interviews, in order to support my interpretation. I will review the master themes in the same order as presented in the analysis. Deeper meanings of the themes as well as the connections between the themes will also be explored. I will then discuss the implications of these findings for Counselling Psychology practice with staff nurses working on acute inpatient wards. Consideration will be given to both methodological reflexivity and my personal reflections before concluding.

The present study aimed to answer the following question:

- What are staff nurses' experiences of compassion on acute inpatient wards?

In addition, the following questions were also hoped to be illuminated on the basis of my findings:

- What hinders and what facilitates compassionate care on acute inpatient wards?

Results suggest that staff nurses' experiences of compassion oscillated in what compassion is in general, what they perceive it to be, and how they experience it in their work. The complexity of their experience is influenced by individual, professional, interpersonal, and psychological factors within the context of an acute inpatient ward.

Main findings

Perspectives of compassion; the ideal

This section aims to answer what are the staff nurses' experiences of compassion within the context of an acute inpatient setting. The findings from the master theme *Perspectives of Compassion; the ideal* suggest that the majority of the participants had variances in how they understood and experienced compassion. Linguistically, terms such 'empathy', 'caring', 'kindness', 'genuineness', 'helping', 'understanding' and 'listening' were noted in their accounts. Despite the lack of a clear consensus of the term, compassion appeared to be an outcome of their intuition, with the nurse participants seemingly making attempts to communicate it in their own unique idiosyncratic ways. The conflation of some of these terms with compassion, in addition to the absence of a psychological understanding of it; is consistent in a wider review of the definitions and meanings of compassion cited by Strauss et al (2006) in the healthcare literature.

The nurse participants also appeared to regard compassion to be an innate quality, of which operates on a continuum, and something that can be regarded as 'part of being human'. This proposal that compassion exists as an innate human trait, or a quality that can't be taught (i.e., existing prior to training) has also been reflected in what other researchers have found (Bray et al., 2014; Vivino et al., 2009; Bramley & Matiti, 2014). However, such conceptualisations didn't appear in sufficient enough frequencies in the findings of this study for it to be assigned a theme, but it is helpful to organise our thinking around that compassion could be seen to be an intrinsic value or quality in this setting. Overall, the nurse participants didn't appear to have a streamlined or formal understanding of compassion by definition, or that which exists within compassionate recovery models for inpatient care for patients, which has significance for compassionate responding geared toward patient care, and the wider ward-based culture.

The perspectives of compassion; the ideal consisted of two constituent intertwining subthemes of how nurse participants experienced compassion, comprising of '*putting myself in your shoes'* as the precursor and *'showing you I'm there - moving toward you'*. Although the interview schedule didn't contain any specific questions regarding compassionate processes, the findings illuminated that participant experiences of compassion appeared to be embedded in relational

terms, and within the nurse-patient dyad, and not independent of it. This relational aspect is also consistent with Gilbert's view that compassion exists 'within relationships', and forms part of a 'flow of interpersonal dances' between the self and other, and embedded in our social mentalities, and innate motivational systems (Gilbert, 2017; Pg. 62). Importantly, Trish (2014) cites that compassion involves the activation of emotions within close and connected relationships, giving credence to this relational aspect of the participant experiences of compassion, of which will be discussed.

In the first subtheme of '*putting myself in your shoes'* five of the nurse participants appeared to conceptualise their experiences of compassion by illuminating that they perceived compassion to be having awareness or recognising suffering in the *other*, i.e., toward their patients. For example, Natalie conveys 'I know what it is like working in that kind of environment' and references 'you have been deprived of certain things'; thus, viewing compassion by appearing to recognise the needs of her patients. Similarly, Mark and Chris also make reference to *putting myself in your shoes* and cites an 'awareness' and a 'willingness to listen', as to how they understand and experience compassion in another. Mark further describes that having an awareness or knowing of someone's needs and not attempting to alleviate it is akin to not being human as he describes *'If you were aware of somebody's needs and were then just ignore them, I would think that's not so much to me like I'm human'.* Interestingly, Maya views compassion in what appears to be through the lens of her own kin relationships in relation to patients, when she describes suffering as *'if I was in that family's position what I would like my family to be treated like if my son, my daughter, my parents, auntie and uncle, if they were in a place and needed care'.* Paul associated attributes such as 'being empathic', having a 'caring nature', as well as 'putting yourself in the service users' shoes' as possible antecedents when explaining his understanding of compassion. He also makes reference to compassion as the 'listening' and 'understanding' of another, further embedding that his lived experience of compassion appeared to be through the minds of others.

When contextualising these findings '*putting myself in your shoes'* could be viewed from the lens of our 'new brain' and higher order cognitive abilities such as mentalization – the minds ability that allows us to simultaneously understand and reflect upon what goes on in our minds, and in that of others; and is distinct from our 'old brain' strategies for basic reproductive and

survival strategies (Gilbert, 2010). New brain capabilities aid us in how best we can successfully navigate within our social roles and relationships, however its processes can cause benefits as well as hinderances depending on our ability to accurately gauge social signals (Gilbert, 2017; Roche, Cassidy, & Stewart, 2013). Gilbert (2010) suggests that the broader in scope our mentalisation capabilities, the better we are at it, and the more likely our ability to be compassionate. Therefore, opening up avenues to further mentalisation based competencies in staff nurses could facilitate enhanced compassionate responding.

Additionally, participants nurses used empathy interchangeably with compassion, and as mentioned in the introduction section empathy infers to a 'feeling with' or 'entering into the experience of another' and is also competency-based (Gilbert, 2007; Pg, 56). Of its two constituent components of emotional and cognitive empathy, of which are suggested to be antecedents to compassion (Batson, 2009), it is the cognitive element that is linked to mentalisation, and other high order capacities such as theory of mind, and intersubjectivity (the ability to share perspectives with others) (Milkulincer and Shaver, 2007; Malle & Hodges, 2005; Zaki, 2014). However, Batson (2009) suggests that having empathy for another's suffering may or may not trigger motivation orientated compassion, i.e., empathy doesn't automatically trigger a desire to help. The implication being that even if inpatient nurses have an awareness of suffering or are able to mentalize aspects of suffering in their patients, this doesn't necessarily always equate to compassionate responding, or in an action to alleviate suffering. As Mark suggests that he sees the 'crunch of [being compassionate] it is being aware of other people's needs and finding an appropriate response'. Bond et al (2008) and Tirch et al (2004) would argue that although the links between compassion (through attributes such as empathy) are complex, motivation is secondary in comparison to how mindful or how aware we are, with the implication being that training programmes that work to increase awareness about the cognitive or emotional processes that can occur in staff nurses in relation to their environment could have the effect, to enact or open up action for compassionate responding.

Lotti and Gilbert (2007) also suggest that the interplay between such mentalisation based competencies and that of our social mentalities is a complex one, and one that gives rise to a neurobiological signature. They highlight that this complexity is influenced by our early attachment histories, individual differences, as well as contextual factors. Additionally,

mentalisation awareness can be hampered by emotional dysregulation such as when we are feeling stressed or threatened (Gilbert, 2010), of which is also cited in the literature on burnout and compassion fatigue (Ahola et al, 2005; Mason & Nel, 2012). For example, Chris illuminates that staff were having issues with 'emotional engagement' and cites 'and when I say listen [to patients] …I mean listen and show some understanding'.

If we are feeling safe within a particular role, mentalisation occurs more optimally. Gilbert (2010) suggests that there is utility in using compassionate mind techniques to train individuals that can create a sense of safeness, and thus enhancing mentalisation awareness in order to foster compassion to the self and others. This is highly relevant for inpatient nurses when working with patients with severe mental illness, those in crisis, and well as within the resource limited constraints on an acute inpatient ward, and when nurses are expected to be compassionate. Currently, as far as far as I am aware training for staff working on acute inpatient wards on compassionate mind techniques has not a formally incorporated into staff training in the same way as patients, despite calls from governmental reports and patient perspectives highlighting its importance in recovery.

Noteworthily, with reference to Maya experiencing compassion through her kin relationships, one could hypothesize that the close proximity of staff nurses to patients providing 24hr care could elicit forms of caregiving and enactments of attachment motivational systems that could potentially mirror that of those of kin relationships (Gilbert, 2005), which in turn could be motivated by a positive reward system for the individuals' involved. Wang (2005) suggests that these processes with respect to compassion are complex and are implicated with certain oxytocin processes for both parties; this could have implications about the possible role that training in compassionate responding that could potentially be involved in the co-regulation of each other's mind (Segal, 2016), i.e., as a two -way regulatory strategy between both staff nurses and patients. Cosley et al (2010) found that compassion as a form of social support could 'buffer' the physiological reactions to stress, which could be an avenue for future research.

In the second subtheme *'showing you I'm there - moving toward you'* the participants experienced compassion that was indicated by a desire or motivation, which appeared as a movement *toward* patients to ease their discomfort or suffering. This movement *toward*

patients, in an attempt to compassionately respond to them, appeared to be done through understanding, empathy, emotional resonance, and in behaviours (via actions), in what could be interpreted as what they view as an ideal compassionate self, that was orientated toward patients.

Six participants attempted to *show* their understandings of compassion *toward* patients through behavioural or practical acts, i.e., doing things for them, in order to impart these motivations. *Putting myself in your shoes* appeared to serve as a precursor to showing compassion. It appeared that it was meaningful for participants to not only engage in practical acts of compassion toward patients, but to do it in a way that patients were able to integrate this into their own experiences of compassion. Practical acts of compassionate behaviour appeared to be initiated by the participants, featuring as a part of their own agency, and moved in the direction toward patients.

For example, Natalie references 'I would go out of my way and go out and get it for them… because I know how important this thing is for them…' and follows with 'knowing that this would make them happy… and that this would even make them understand that they are not just patients… and that they are human beings… and that they have been listening to and heard…'. Patients being able to comprehend or assimilate these acts of compassion appear to be an integral part of this subtheme and appeared to be an aspect that underpinned compassionate experiences for participants. The aspect of compassion being visible toward patients appeared to hold relevance, with John referencing 'tangible elements of compassion' and possibly implying that this relational interplay was a significant feature underpinning his experiences of compassion and how it may be linked to professional identity. Making patients feel understood relationally, and with empathy, has the potential of mimicking secure attachment systems and integral to recovery in mental health. Music (2017) suggests that actively fostering these kinds of relationships lead to neurobiological gains, such as increases in 'vagal tone', 'oxytocin', as well as 'emotional flexibility', which can be extrapolated towards patients and staff alike.

Practical aspects of conveying compassion also included non-verbal elements such as 'listening', using a 'nice tone of voice', and being 'respectful'. Sinclair et al, (2016) also found

that these elements were linked to compassion in his review of compassion in the wider healthcare literature. Other elements such as 'showing your kindness' and 'showing empathy' appeared to be referenced as a way of showing genuine or authentic compassion. Compassion in the form of advocacy toward patients was also an aspect that featured as part of compassionate experiences for nurse participants, which was illuminated by Paul in reference to changing a patient's medication when he referenced 'here you actually have to go out of your way to resolve things'. Similarly, in a constructionist discourse analysis, Brown et al, (2014) identified practical repertoires used by healthcare practitioners in acute mental healthcare (N=20), that utilise 'practical, physical, and bodily' aspects of compassion (like doing things for patients like playing a game or taking them outside for a cigarette) as a means to 'open up' avenues for compassionate mental health work. What is particularly noteworthy was that this study identified understandings of compassion had more to do with actions, and less so on our innate motivational systems, making understandings of compassion in this instance to be embedded in practical work.

It was clear that the practical acts of compassion imparted were subjective on the part of the participants, appeared relationally, and also were subject to the needs of the patients at the time, as well as being dependent on what appeared to be the participants' own capacity for delivering compassion, of which will be discussed in more detail in the following section.

In summary, the above two subthemes appeared to map onto the two psychologies of compassion model suggested by Gilbert (2010), in which the two dimensions include the psychology of engagement, and the psychology of alleviation. The first dimension involves the ability to notice, turn toward, and offer sensitive engagement with suffering (as is the case with *putting myself in your shoes*); and the second dimension involves action to orientate oneself toward attempting to alleviate that suffering (as is the case with *showing you I'm there - moving toward you*). When examined together the two subthemes appear to demonstrate a flow by participants to oscillate between the two positions, possibly due to their own personal resources, which appeared to form interrelated aspects of their experiences. This aspect again is in line with the operationalised definition of compassion put forward by Cole & Gilbert (2011) that compassion is "a sensitivity to the distress of self and others with a commitment to try to do something about it and prevent it".

Overall, the implications of the findings suggest that the nurse participants know and are aware of what compassion is and what an ideal compassionate response might look like, albeit informally, even if they are unable to act in line which what appeared to be consistent with their personal or professional values as part of their job. However, this ideal scenario, appeared to be narrowed at times, and appeared to have its caveats as will be discussed in the following section in the 'conflict within', in which the themes displayed a movement *away* from patients, and appeared to be inhibitors of compassion.

The conflict within; inhibitors of compassion

This section aims to address the second part of the research question, of what hinders and what facilitates compassion. The master theme *the conflict within; inhibitors of compassion* offer a lens into the participant's internal and external processes that appear to hinder compassion. Three subthemes were found within this master theme which included *leaning away from you*, *difficult emotions*, and *responsibility - the buck stops with me.*

The previous section illuminates, how nurse participants construct and understand compassion, as well as the demonstrative acts of compassion, that they try to employ in line with their own personal motivations and values. The findings from this section offer an insight into the real-world aspects of working life on an acute inpatient ward and how it relates to compassion and compassionate responding to patients. The findings suggest that nurse participants have a desire to engage in care and compassion, towards patients, as they understand it; but that this desired flow of compassion, is modulated against the backdrop of when to engage, disengage and when to compassionately come back. This dichotomy permeated throughout their accounts and appeared to be dynamic and situationally adaptive.

In *The conflict within, inhibitors of compassion*, like in the previous section, difficulties with compassion and compassionate responding appeared to exist within interpersonal relationships i.e., between nurse-patient, or between nurse-nurse interactions. As a point of reflection most of the nurse participants narrated their experiences alternatively between the first- and- third-person perspective, i.e., sometimes opting to illuminate their experiences of compassion through third person observations of their colleagues and was especially evident in instances of

what could be viewed as uncompassionate responses. In psychodynamic terms this could be constructed as projective identification.

In the first subtheme of '*leaning away from you'* nurse participants appeared to identify difficulties in engaging with patients, which were seen as hindering compassion and compassionate responses. Six participants described aspects of this, which appeared to be experienced in behavioural, cognitive, and emotional terms. John overtly described aspects of *'leaning away from you'* behaviourally by using terms such as 'restrictive interaction' and through the use of what was described as 'boundary language', or through the use of an 'abrupt' or 'direct' tone of voice as strategies to reduce engagement with patients. As this was not a first-person observation it was difficult to probe further as to whether this was an aspect of conscious or subconscious processes. John also appeared to be illuminating instances of communication strategies used by nurses that could be perceived as coercive on their part and reducing a patient's autonomy when he references 'it is this way or no way' as part of this subtheme.

Maya also describes observations of similar proximity reducing behaviours, which appeared to include acts such as physically moving away or avoiding eye contact with patients, of which seemed to include accompanying stigmatising judgments toward them. Natalie reiterates this in describing the use of negative or pejorative comments in her experiencing of when staff refer to patients. Both of these appear to precede corresponding distancing behaviours involved in a lack of compassion and compassionate responding towards patients.

Upton (2018), in a study investigating compassion fatigue and self-compassion across five acute medical care hospital wards in nurses (N=24), found similar results. Behavioural avoidance of difficult patients was cited in 40% of the respondents. Levels of avoidance increased particularly in the age range between mid 30s-40s, with further increases in avoidance in in those respondents aged 41- 45 years. The authors postulate that this may not just be work related, but a juncture of life when the pressures of work and family dynamics may collide.

Other instances of *'leaning away from you'* included participant nurses' interpretations of their nurse colleagues not appearing to 'understand' when a patient is 'upset' or 'distressed', and not

appearing to be empathically attuned to the mental health concerns of their patients, i.e., John illuminates that and that they can show a 'cold element' towards patients.

Ingrid, Mark and Paul attempt to make sense of some of their experiences when asked about their experiences of compassion. Ingrid contemplated 'I don't know what goes on in some people' and articulated that 'they are not there'. Mark describes 'everyone has got compassion'… 'but they can somehow restrict it all' and is possibly speaking from an autobiographical perspective. He describes the use of 'self-defensive' strategies, and the use of 'barriers' in order to 'cope'. He described his awareness that patient experiences can be 'terrible' and alludes to conflictual feelings of guilt about possible lapses in compassion and compassionate responding. He offers his thoughts as to why this restriction of compassion may be occurring from a third person perspective and references 'I've got enough problems I can't possibly cope with all of their problems as well' and references 'I'm sure I have done it'. Paul also eludes possible lapses in compassion and that 'some people have a temper' as a way of coping in a 'stressful environment'. Similarly, Natalie attributes that a lack of compassionate responding could be due to the fact that staff are having a 'harder time' than some of the patients.

In contrast to the previous section, it appears that the same participants are describing lapses or a narrowing in the core *attributes* of awareness and engagement, required for compassion and compassionate responding as theorised by Gilbert and Cole-King (2011), and *lean away* from patients as what could be hypothesised as a form of coping or self-protective strategy.

Noticing, feeling, and responding have been identified as sub processes involved in compassionate responding (Kanov et al., 2004). Atkins & Parker (2012) argue that an individual's *appraisal* of the situation is important for individual compassion and should be added as a fourth dimension to the attributes of the compassionate mind model. They rationalise that noticing suffering in another elicits an empathetic concern; seen as an antecedent to compassion, and that this corresponding compassionate response is dependent upon the actual appraisals being made. Appraisals of the situation (primary appraisals) versus appraisals of one's perceived ability to cope with the situation (secondary appraisals) i.e., self-efficacy, is seen as important for compassionate responding (Folkman et al., 1986; Atkins & Parker, 2012);

and seen as a dynamic process involving appraisals, emotions, with the environment and vice versa. In this instance it appears as if Mark and Natalie are describing aspects of self-efficacy that could be implicated in compassionate responses.

According to Gilbert's (2009) two psychologies model of motivation and competencies for compassion mentioned previously, *leaning away from you* and the ways in which it has been described above could be interpreted as lapses in the core *attributes* of awareness and engagement, specifically in the areas of sensitivity to distress, empathy, distress tolerance, and non-judgement. Participants appeared to have appraisals that their colleagues were unable to alleviate suffering in patients, or offer the appropriate reflection and action required to attend compassionately, to the mental health needs of patients. These instances appeared to be counterintuitive to recovery model ideals, and the objectives of the compassionate care prerequisites in cited as vital in ward-based environments.

As mentioned, *leaning away from you* appeared to be embedded relationally. Coatsworth-Puspoky et al (2006) found that when looking at patient perspectives there appeared to be problems with forming relationships between nurses and patients when patients perceived that the nurses were inaccessible to them. This was characterised by 'barriers' and 'mutual avoidance' that they cited were 'detrimental' to the relationship. They identified three phases in the nurse-patient relationship that demonstrated this with the first phase coined 'withholding support', which patients appraised as a conscious choice on the part of the nurses and saw it as a lack of interest and care. The middle phase was characterised by nurses avoiding patients, with the final phase charactered by their appraisals rationalising these observations between their expectations of care and the realities, for example appraisals were connected to understandings of possible nursing shortages. These observations were not all across the board, with some nurses offering support. What we know from psychotherapy-based studies, the quality of the relationship and how it is perceived is a better predictor over outcomes for patients over and above specific models (Cooper, 2008). Addressing components involved in *leaning away* could open up avenue's for more therapeutic nurse-patient interactions, which could in turn open up opportunities for compassionate responding.

In the second subtheme participants identified experiencing *difficult emotions* which appeared to be a common thread throughout the interviews. Four participants offer specific descriptions of difficult emotions experienced with the corresponding situational triggers, which were predominately from the 'I' perspective. Experiencing difficult emotions often preceded difficulties in engaging compassionately with patients as described in *leaning away from you.* There also appeared to be a reduction in compassionate language in the interviews when experiencing difficult emotions. These emotive descriptions included feeling hurt, uncomfortable, frustrated, having intense emotions, and what appears to be feeling afraid in the context of their work.

Paul appears to be describing fear and avoidance when he describes experiencing sexually threatening advances from a patient when he references 'I feel very uncomfortable being out there...you don't want to go to his room or anything like that' and 'I don't really engage unless I have to'. Paul was however able to re-frame his experiences in the context of his awareness of the mental health discourses as part of his work, describing the patient as being 'unwell'. He was also able to seek support from a colleague, and therefore in this instance was able to demonstrate a flexibility, in compassionate responding. Ingrid also appeared to be experiencing difficult emotions which appeared to be feeling afraid, feeling mistrust towards unfamiliar or agency staff, which corresponded to feelings of isolation and helplessness. This appeared to be in response to a colleague having been violently attacked on a ward. Ingrid appeared to be psychologically affected by this, which lead to ruminations and further reinforced her fears.

Behaviourally, Ingrid appeared to display an attitudinal change towards unfamiliar staff and unfamiliar patients, that involved a cautioned stance with engaging with them, and therefore in this instance she was not ready to demonstrate a flexibility in compassionate responding to her fears, like Paul had done.

The existing literature in that looks at group dynamics suggest that when people experience adversity, they attempt to form a group of a common purpose or goal. In Thompson's (1999) U.S study on an acute ward, patients described a certain 'camaraderie' or 'solidarity' with other patients when experiencing adversity, however in some instances some participants reported

feelings of vulnerability as well. These group dynamics could feature for nurses on inpatient wards when they feel overwhelmed and thus could hinder compassion.

Similarly, John describes experiencing difficult emotions of 'hurt' and 'frustration', with the former being relationally embedded in what he experiences as racially motivated behaviours towards him he has constructed as 'silent', 'malicious' and 'conniving'. The latter is related to task demands and possible fears of reprisal if they are not done. Chris also describes difficult emotions from a third person perspective, and describes staff experiencing 'all-encompassing emotions' that inadvertently trigger angry, abusive and physically threatening behaviours from patients. He describes staff as 'they don't offer themselves the opportunity to reflect' or view a patient's response as due to 'not being listened to'.

Upton (2018), cited earlier, similarly found heightened emotions and arousal in their sample of nurses. Approximately 60% of the sample size reported symptoms of 'heightened arousal, sleep issues and hyper vigilance'. Higher levels of arousal were especially prevalent in those aged 36 to 55 years old. The qualitative interviews offered further insights where the nurses illuminated experiencing difficulties in managing their emotions, as well as citing a 'heightened anticipation' when having to engage in what was deemed as stressful work scenarios. Emotional avoidance was also reported by the respondents; with 46% reporting a shortened future, and 38% experiencing emotional numbing i.e., feeling 'desensitised and unmoved by the death of a patient'.

In the third subtheme *responsibility - the buck stops with me* participants appeared to view aspects of responsibility to be inhibitors of compassion and compassionate responding. The participants had different views on what constitutes responsibility. Responsibility appeared to feature in the areas of a *them versus us* mentality i.e., viewing agency staff as not part of the team; feeling responsible to complete task demands; and feeling responsible for family and related commitments outside of work. Four participants described responsibility in these areas.

Natalie and Ingrid both illuminated experiencing negative attitudes either toward agency staff, support workers or unfamiliar staff in terms of responsibility. Natalie described that 'they [support workers] don't act as if they have a sense of responsibility for the team' and linked

theoretical knowledge and a lack of a university degree as playing a role in hindering compassionate and empathetic responses. Accountability and intrinsic motivations about the job role also appeared to be experienced as contributing to lapses in compassion. She describes support staff as having an 'attitude' when asked to do practical tasks, i.e., helping to change a patient due to incontinence, which also highlighted possibly communication difficulties, and a lack of clarity of job role. This has parallels to previous sections where participants viewed *showing* compassionate to be aspects of compassionate responding. Natalie also indicated that training in compassion would help to foster a better understanding of mental health.

For Ingrid responsibility also appeared to feature through the lens of a *them versus us mentality* when she describes 'they have got no responsibility…but not like us if you know what I mean…to the patient…so I don't think they show much compassion to the patient', and thus equating responsibility to compassionate responses. This *them versus us* mentality is further re-iterated when she differentiates between 'good' agency staff and 'bad' agency staff. Like Natalie, Ingrid also questions the intrinsic motivations of agency staff regarding their choice of job and interprets this to be monetary. Ingrid further differentiates responsibility in terms of temporal factors, i.e., full time staff having more responsibility than agency staff. She describes what appears to be an overwhelming sense of burden and refers to a joint narrative between her and her colleague to describe feeling responsible for patients as well as other unknown and unfamiliar staff when she describes 'You are not only responsible for the patients…you are responsible for them three members of staff or whatever ...how they work ...what they are like' It appears as if 'the other' in these instances are viewed with scepticism and seen as untrustworthy. Mark also appears to be describing dual expectations in terms of responsibility originating from the workplace in terms of managerial expectations, as well as expectations from family and his financial commitments at home when he describes 'Sometimes this conflicts...and sometimes if you have a bad day at work, and sometimes I do bring it home with me which is wrong' illuminating possible feelings of guilt and difficulties with self-compassion. There have been relatively few studies looking at team dynamics in this setting, however in some cases team cohesion has been conceptualised as part of staff morale (Totman et al., 2011). DiMeglio et al. (2005) found that staff engaging in team building exercises in a general hospital reported enhanced team cohesion, better interpersonal relationships and job satisfaction over a

one-year period, highlighting the possible utility of staff training to foster better group alliances and reflective practices that cultivate compassionate cultures.

Maya describes responsibility in relation to task demands and appears to be conflicted between attending to a patient and what she described as 'and I like to get things done myself because there aren't any repercussions…and if anyone says the work isn't getting done if it was my responsibility...' It appears as if the aspect of repercussions, and associated fears of criticism, to do with task demands, are incongruent with potential desires to attend to a patient, and therefore can play a role in inhibiting a compassionate responding.

To summarise, the findings from the two master themes suggest that the nurse participants appeared to have an understanding of compassion and had a motivation to demonstrate it, benevolently to their patients, however, at the same time they appeared to be overridden by thoughts, negative evaluative judgements towards patients and colleagues, experienced difficult emotions, and had feelings of responsibility, which appeared to cause them to disengage, avoid, withdraw, or appear less mindful with respect to compassion and compassionate responding towards patients. These processes appeared to be operating in parallel hampering a consistent compassionate response.

Consideration of these interpretations made me re-visit the literature in order to help contextualise the findings as a whole. The construct of psychological flexibility could be helpful to organise some of the findings around (Hayes et al., 1999). It refers to a *conscious* repertoire of human abilities that are used as a means to persist or adapt to situational demands which imply engagement with the present moment (Hayes et al., 2006; Bond et al., 2006). Repertoires include sophisticated theory of mind capabilities; to recognise, to shift mindsets, and adapt behaviours in a manner that doesn't compromise on personal or social functioning and is in congruence with ones chosen values and goals (Bond, Flaxman, & Bunce, 2008; Bond et al, 2006; Hayes et al., 2006; Kashdan, 2010).

The processes of psychological flexibility are dynamic with individuals deliberately balancing what is important to them and making decisions about what to give their resources to on a moment-to-moment basis, and within the context of fluctuating internal and external demands

(Atkins & Parker, 2012; Kashdan, 2010; Sonnetag et al, 2010). Individuals who are more psychologically flexible are better at noticing and attending to their inner world and are able to do so in an open and non-judgemental accepting way, i.e., they hold in mind that their thoughts and emotions are arbitrary and fleeting (including those that are unwanted or negative) and are able to negate being overly guided by them (Bond, Flaxman, & Bunce, 2008; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Brion & Veldhoven, 2012). Contrastingly, individuals who are less psychologically flexible, i.e., inflexible, have a tendency to be more sensitive to context, and can therefore divert more of their attentional resources towards their inner world, i.e., they focus more on these unwanted thoughts and emotions, which contributes to a loss of connection to the present moment (Atkins & Parker, 2012; Brion & Veldhoven, 2012).

This inward focused tendency can result in attempts to 'control, change, avoid, supress, or over analyse' these unwanted parts of their experiencing, to the extent of removing themselves, or escaping from the situations or events that are seen to have caused them (Bond & Flaxman., 2006; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). An unintended consequence of this, is a reduced internal capacity, which inadvertently has the effect of increasing the actual frequency of these inner experiences, which further compromise an activation towards chosen values and goals (Wenzlaff & Wegner, 2003).

What can be contextualised as psychological inflexibility, as described above, has also been referred to in the literature as experiential avoidance (EA), and has been specified to be an unwillingness to engage with private inner experiences such a 'bodily experiences, sensations, emotions, thoughts, memories, images, and behavioural dispositions' that are uncomfortable or unpleasant for the individual (Bond, Hayes, Baer, Carpenter, Guenole, Orcutt, Waltz & Zettle., 2011; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Hayes et al., 2005). Conceptual overlaps exist between EA and other related constructs, such as 'thought suppression, avoidance, coping, reappraisal, and emotional suppression', as well as unhelpfully being described as aspects of EA Chawla & Ostafin (2007).

Experiential avoidance or psychological inflexibility can be re-specified or re-configured in this context in light of the findings of this study when looking at the subthemes of *leaning away from you, difficult emotions, and responsibility – the buck stops with me.* While a full review of

experiential avoidance and psychological inflexibility are beyond the scope of this discussion, a few key observations highlighted in the literature are worth noting. EA has been associated across transdiagnostic mental health difficulties such as depression, post-traumatic stress disorder, substance abuse, and social anxiety (Bond et al., 2011; Kashdan et al., 2013; Leven et al., 2018). It has been studied within the context of clinical perfectionism and worry (Santanello & Gardner, 2007), as well as being a factor occurring in relationship difficulties (Reddy et al., 2011). Interestingly, a study conducted in a high intensity hospital setting concluded that avoidance or suppression of inner experiences led to increased stress, depression, and workplace absenteeism, with processes of problematic communication and interpersonal difficulties being implicated in the findings. This was found to be independent of actual skill set in this setting (Monestes et al, 2016).

Psychological flexibility, or reducing experiential avoidance is a core therapeutic target of Acceptance and Commitment Therapy (ACT: Hayes, Strosahl, & Wilson, 1999; Fletcher & Hayes., 2005), and is an applied third wave Cognitive Behavioural Therapy intervention, which posit that psychological difficulties are rooted in thought processes rather than thought content. It includes six processes (depicted in a helaflex) which promote psychological flexibility interactively; it includes mindfulness (present moment contact), defusion (detachment from thoughts), acceptance (non-judgemental acceptance of inner thoughts and sensations), self as context (observing self), values, and committed again toward chosen goals (Hayes et al, 1999). The utility of ACT in targeting psychological flexibility, has had promising results especially in organisational settings, such as in increasing coping abilities, quality of life, as well as lowering stress (Ramaci et al, 2019; Petralia et al, 2018).

Researchers such as Trisch, Schoendorfe, and Silberstein (2015) have sought to assess how the particular processes of compassion and psychological flexibility relate to one another, in order to open up new areas for the cultivation of compassion in the self and others (Tirch et al., 2014). Additionally, Atkins & Parker (2012) also propose that psychological flexibility contributes to 'increases in perceptual, cognitive, affective, and behavioural aspects of compassion'. Compellingly, Hayes (2008a) suggest that the underpinnings of both compassion and self-compassion could potentially emerge from the six-core process of psychological flexibility, and in fact suggest that compassion may "be a value that emerges inherently from the psychological

flexibility model-and the only value that does so" (Hayes, 2008c in Trisch et al., 2014 Pg 32). Theoretically, and relevant to findings from this study psychological flexibility considers *motivational aspects* towards being guided by our values and goals, as coming secondary to how *'mindful'* we are in regard to the current situation (Bond et al, (2008). Therefore, it may be helpful to prioritise interventions targeted at enhancing mindfulness prior to motivational aspects concerned with compassion and compassionate responding.

Each of the processes conceptualised in the Compassion Focused Therapy (CFT) model can be related to the six processes of ACT, which can together promote psychological flexibility (Trisch et al., 2014). To reiterate, within the CFT model exist two central aspects of compassion, '*Attributes'* (corresponding to the psychology of engagement), and '*Skills training'* (corresponding to the psychology of alleviation). Gilbert (2009) suggests that the first one involves developing certain competencies such as the motivation to care for well-being, sensitivity, sympathy, distress tolerance, empathy, and non-judgement. The second one involves reflective action in areas such as reasoning, behaviour, sensory, feeling, attention, and imagery. The process of both ACT and CFT do not directly overlap but can be helpful to organise our thinking around. I will attempt to discuss the overlaps put forward by Trish et al (2014) deemed relevant to the findings, which could conceptually and practically provide knowledge for interventions, and how such processes could be targeted in interventions for inpatient nurses, potentially opening up opportunities for compassion and compassionate responding. The relationship between psychological flexibility and compassion specifically for inpatient nurses has not yet been documented in the literature, highlighting the possible original contribution of these findings.

Sensitivity and Present Moment

As mentioned, in CFT, sensitivity is one of the key attributes required for the cultivation of compassion. It entails developing the capacity to be sensitive to the suffering of others, as well as our own reactions to it, as it arises; to maintain open attention, and to turn toward suffering and not away from it (Gilbert and Cole-King 2011). Tirch et al (2014) suggest that this is similar to the present moment contact in psychological flexibility (Hayes et al, 2012). It involves deliberately attending to present moment experience, as well as diverting attentional resources toward experience, even if they are difficult, rather than attending to inner processes such as

pain, shame, judgments, or narrative constructions of the past or future (Tirch et al., 2014; Atkins & Parker, 2012). The findings suggest that the nurse participants were *leaning away* from patients, and avoidant of attending to difficult experiences. The evidence suggests that mindfulness and attentional training enhances the capacity to be in the present moment, and fosters more opportunities for flexible focused attention in the moment, and therefore having the potential to enhance compassionate responding; in fact classical mindfulness training has been shown to cultivate present moment awareness and more holistic mental states including compassion (Baer, 2003; Garland et al., 2010; Tirch at al., 2014; Rapgay, 2010; Tirch, 2010; Wallace, 2009). Therefore, mindfulness and attentional training techniques from ACT could potentially be incorporated in hybrid interventions to enhance compassion and compassionate responding in staff nurses.

Sympathy, Empathy, and Self -as- Context

Another process which promotes psychological flexibility is self-as-context, and it refers to an observing approach to self. In essence, it is the creation of psychological space where one can observe self-conceptualisations, in a self-reflective capacity, as another aspect of the flow of experiencing, without being overly guided by them (Bond et al, 2016; Atkins & Parker, 2012). Through the perspective of self-as-context, individuals view their experiences as just a part of experiencing, but not the whole (Bond et al. 2016). Research suggests that when thoughts and feelings are viewed from this observational role, fluctuating internal events are less unhelpful or emotionally impactful (Foody et al, 2013). Processes can include flexible perspective taking, i.e., akin to mentalisation, to view suffering in another without identifying with personal schemata or narratives to do with the self (Hayes et al, 2012; Tirch et al., 2014). In CFT, although attributes of sympathy and empathy are conceptualised differently, they both involve aspects of flexible perspective taking (Tirch et al., 2014). Similarly, CFT also incorporates process to enhance flexible perspective taking, sympathy, and empathy, such as imagery, contemplative practices, and interpersonal exercises. Importantly, self-as-context has also been linked to Neff's (2003b) components of self-compassion, i.e., mindfulness, self-kindness, and common humanity. Tirch et al (2014) suggest adopting an observing role to self-as-context aids in a 'disidentified' relationship to our experiences, and that the mindfulness and common humanity components of self-compassion can offer an 'activation' of flexible perspective taking in ACT described above, and thus together in conjunction can reduce the some of the

unhelpful self-conceptualised narratives of our experiencing into more helpful or less threatening ones (Tirch et al, 2014; Atkins and Parker, 2012).

Nonjudgement and Acceptance

The construct of acceptance in psychological flexibility, is the acceptance of unpleasant thoughts without attempting to change the form or frequency of them and is the opposite to experiential avoidance (Fletcher et al., 2010; Hayes at al., 2012). It doesn't imply resignation and can occur at the same time as motivated action (Atkins & Parker, 2012). In compassion acceptance implies remaining open to our awareness of suffering in ourselves and others, despite the difficulty (Tirch et al., 2014). In response to fears, difficult emotions, or self - criticism CFT can help to cultivate a 'sensitive', 'non-judgemental', and 'accepting' stance to human suffering (Tirch et al., 2014). Acceptance and compassionate motivation to stay in contact with suffering can make it more likely an individual is better able to extend compassion. Viladarga et al (2009) found that mindfulness predicted levels of burnout in addiction counsellors when they engaged in negative appraisals about their clients.

Distress Tolerance and Defusion

A key aspect psychological flexibility and therefore mindfulness is defusion from thoughts and feelings (Hayes et al, 2012). Defusion processes extend compassionate processes to the self and other. It does so by creating space between the individual and the contents of their thoughts, and thus reducing the likelihood of being dominated by events like ruminations, or negative evaluations of others that can potentially occur in the mind (Hayes et al., 1999). If an individual is more fused with their thoughts, they will find it difficult to view situations more than one dimensionally, and more likely to react automatically to them (Atkins & Parker, 2012). For example, Hayes et al (2004) found that multicultural training reduced stigmatising attitudes originating from drug and alcohol counsellors towards their clients, as well as burnout after a 3 month follow up. This training improved 'self-care' and 'caring' for others (Atkins & Parker, 2012). Masuda et al (2007) found similar results of reduced stigma in individuals who identified as experientially avoidant or identified with judgemental thoughts. In CFT, distress tolerance differs from defusion, but having the capacity to separate from complex emotions and habitual mental events involves defusion. If we are able to accept and defuse from difficult internal events and schemas, and tolerate distress, the more we can turn toward suffering in the self and

others, and therefore are more able to open our evolved care-giving capacities in the compassionate mind model (Tirch et al., 2014).

It is only recently that psychological flexibility has emerged as the cognitive process that underpins the mechanisms of ACT, compassion, mindfulness, and resilience. If you are not flexible in cognitive, emotional, and behavioural ways, one can become stuck – and shift attention in particular ways that can reinforce aspects of these experiencing. Compassion, mindfulness, and resilience can teach people to be more flexible in the way they feel and behave, which in turn can foster more enhanced compassionate responding. In terms of treatment interventions, the findings suggest that inpatient nurses lacked a formal and scientific understanding of compassion, so clarifying compassionate values (i.e., through psychoeducation and motivational aspects of compassion) through staff-based interventions could make compassion something more understood and more formulised in their daily working lives. Compassionate care case formulations could be incorporated into treatment plans for patients to enhance the focus of a compassionate mind mentality. Techniques to address experiential avoidance could open up further avenues for compassionate responding in the form of ACT based mindfulness and attentional techniques described above to keep the focus on a movement *towards* patients to negate aspects found in this study that led to *the conflict within, inhibitors of compassion.* Incorporating these interventions could benefit both nursing staff and inpatients as well as the wider ward environment, as well as opening up avenues for future research.

Strengths and Limitations of the Study and Future Research

There were a number of strengths and weaknesses identified in the study.

An obvious limitation of this study is that was a small-scale study. Recruitment was conducted from two inpatient units within the same hospital. Participants' exposure to similar systems and processes could cause issues of generalisability that would be difficult to extrapolate to other hospital settings. A larger scale study across a wider range of hospitals would be helpful to compare the findings and to determine if they are typical, and to yield other perspectives. Repeating this study from an international perspective could also yield further knowledge into the area.

Other limitations include difficulties inherent with self-report measures, such as memory bias and accurate recall. A self-report limitation suggested by the findings, were elements of a self-serving bias, where participants attributed negative events to external factors or other individuals. Situational issues may also have affected the findings; whilst attempts to interview participants away from their individual ward setting, the interviews still took place in their place of work. This may have led to perceptions of reduced anonymity and fear of appraisals. Although, not evident in the interviews there was at least one participant nurse who appeared more open pre- and post-interview than during the interview, the reasons of which are not possible to ascertain.

Particular methodological issues were also identified. Whilst IPA affords a deeper understanding of the complexities of individual lived experiences and in making sense of those experiences, it doesn't incorporate contextualised social processes or their consequences for participants. Using a grounded theory approach, which doesn't assume generalisability, could have been useful to understand the types of problems that exist in social sense, and the processes a person uses to deal with them. It may have provided a greater understanding of the problems associated with a ward setting with respect to compassion, thus generating theory. Unlike IPA, grounded theory takes a top-down view rather than a bottom-up view with regard to the wider context.

In terms of the strengths of this research, the open-ended questions in IPA, yielded subjective and experiential psychological accounts, to identify particular nuances of compassion that would have been difficult to access via quantitative methods that may have been more prescribed in nature.

Another strength of the study is that it is a newly emerging topic, and there is a dearth of studies for compassion in inpatient settings, with studies of compassion being more patient centric. Given the fact that compassion is increasingly being incorporated into mental health recovery models for patients, it seemed poignant to address the gap from a staff perspective, which gave an insight into the concept of compassion in acute inpatient wards.

As far as I am aware no such study exits in the UK that explores nursing staff experiences of compassion using an IPA methodology in this setting. In fact, Rydon-Grange (2018) has highlighted that there 'has yet to be a review of the psychological underpinning of compassion in healthcare' in general.

In terms of future studies, this research has focused on compassionate responding, and at its inception the construct of self -compassion was still an emergent topic in mental health, and less so in acute inpatients setting. Since then, it has gained more traction as a construct predominately because of Neff's (2003b) Self Compassion Scale, which has a good construct validity (Tirch et al, 2014). The findings suggested that self-compassion is highly likely to be relevant in experiential avoidance processes and psychological flexibility, so future studies could be developed using a mixed method design to incorporate this scale to see if any of these findings emerge again as well as new perspectives.

Summary of Treatment Recommendations Based on Research Findings

Below I have highlighted interventions of how the findings can be applied for staff nurses in this setting. It is designed to inform thinking and doesn't assume generalisability, due to its nature as a small-scale study. It should be tailored toward individual needs with respect for the personal subjective needs of an individual in line with the humanistic principles of counselling psychology.

- **Psychoeducation about Compassion:**
- Teach psychological understandings of compassion
- Educate about the compassionate mind frameworks
- Utilise compassion focused case formulations
- **Clarify Values:**
- Discuss and ascertain value-based aims and goals
- Explore motivational aspects of compassion and obstacles
- **Address Experiential Avoidance:**
- Facilitate deliberate attention to the present moment (via mindfulness-based strategies and attentional training)
- **Emotional Regulation:**
- Learning to tolerate and separate from complex emotions
- Foster acceptance and defusion (via mindfulness-based strategies)
- Facilitate an observing approach to self (via flexible perspective taking or mentalization based therapies)
- Teach theory and principles of the CM affect regulation model to facilitate self-soothing
- **Using the Therapeutic Alliance to Foster Compassion**
- Provide a safe space
- Facilitate Staff Training in diversity, inclusion, and best practice
- Group work bringing together permanent staff and agency staff for reflective practice and fostering better group alliances
- Individualised interventions

Relevance to Counselling Psychology Practice for Individual Staff Nurses on Acute Inpatient Wards

Understanding the Influence of Context

Understanding the influence of context is important for counselling psychologists working in the NHS where this study took place. The inpatient arena has historically been the forte of the dominant medical model, which albeit has its place; especially for patients who have severe mental illness, and in need of medication. However, the culture of the medical model has become normalised within the wider system, and from what the findings suggest in *the conflict within*, staff nurses also feel system wide pressures; that places emphasis on the individual to 'fix' the problem, with less emphasis on the legitimate concerns such as a lack of resources and increased task demands. Frost (2012) cites that tensions that exist between counselling psychology and the medical model and considers how humanistic perspectives of counselling psychology can bridge the divide between the two. A key principle of counselling psychology is the prioritization of an individuals' subjective and intersubjective experience, and above objective measures that feature as part of job roles (Cooper, 2009). Counselling psychologists are increasingly taking up roles within the NHS and can be best placed to help staff nurses integrate their subjective experiences within the context of their work, and also at a time where there is increasing recognition of the need to find flexible and creative ways of working, within inpatient settings (Wood et al., 2019).

Pluralistic Practice with Staff Nurses

Counselling psychologists adopt a holistic stance towards human distress and use formulation and co-operate enquiry to facilitate this (Du Plock, 2010). This helps to locate client's behaviour and experience within a biographical, developmental and social context. Counselling psychologists are encouraged to draw a wide range of theoretical models that would be helpful to use with clients who are experiencing difficulties, and also to look for new ways of working within paradigms that would suit the individual within a given context and time (Milton, 2010). In this study staff nurses experienced difficulties, which could be

conceptualised in various different ways in the literature; for example, interpretations for the master theme the *conflict within*-inhibitors of compassion could be conceptualised from a number of different theoretical bases such as burnout or emotional dysregulation. Through this qualitative piece of work, I felt able to view participant experiences from the construct of psychological flexibility and experiential avoidance, which has only recently emerged as the cognitive process that underpins the mechanisms of ACT, compassion, mindfulness and resilience. These could be used in new ways of working to open up awareness of *leaning away* from patients; so that staff nurses can become more growth focused and actualise their potential in ways that are in line with their values, goals and motivations, which again is another key principle for counselling psychologists to facilitate (Kasket, 2012). Counselling psychologists because of their pluralistic stance can pay attention and tailor interventions towards the unique aspects of individual experiencing, in the here and now, as well as doing so by the robustness of evidence-based practice within the social context (Frost, 2012). As the findings from this study suggest that a lack of compassionate responding doesn't necessarily equate to a lack of compassionate motivation, and as mentioned in the discussion section, appraisals of the situation can narrow focus, and therefore influence pro social compassionate behaviour (Paley, 2013; Atkins & Parker, 2012). Amalgamating various theories in conjunction to the subjective experience for staff nurses, can help to normalise and validate these experiences individually and within the wider team.

A Restorative Relationship

The humanistic roots of counselling psychology have given credence the to the growing evidence base that the therapeutic relationship has more restorative power for positive outcomes than specific techniques (Frost, 2012). A lot of the inhibitors of compassionate responding appeared in and between relationships, such as in experiences of fear, or in the mistrust of others. The therapeutic space could offer a relational stance in which restoration for staff could be fostered, using the relationship to validate and attend to subjective experience in addition to a tailored evidence intervention.

Reflective Statement

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Appendix

Appendix 1: Participant Information Sheet

Appendix 2: Demographics Form

Appendix 3: Consent Form

Appendix 4: Interview Schedule

Appendix 5: NHS R&D Governance Approval Letter

Appendix 6: Ethics Release Form

Appendix 7: Peer Review Form

Appendix 8: Emergent Themes For Paul

Appendix 9: Transcript Sample

Appendix 10: Reflective Diary Sample

North East London NHS
NHS Foundation Trust

CITY UNIVERSITY LONDON

Mental Health Services

Participant Information Sheet

This information sheet has been reviewed by the North East London Trust Research & Development Department

Study Title: Exploring staff experiences of compassion in acute inpatient settings.

You are being invited to take part in a research study about staff experiences of compassion working in acute inpatient settings. This research study is a required part of the researchers Counselling Psychology Doctorate qualification. This information sheet explains why the research is being done and what it involves. Please read this information carefully and discuss it with others if you wish. Feel free to ask the researcher if there is anything that is not clear or you would like more information about. Please take time to decide whether or not you wish to take part.

University Research Ethics Committee

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact the Secretary at: , Secretary to Senate Research Ethics Committee, Research Office, E214, City University London, Northampton Square, London, EC1V 0HB; Email:

Principal Investigators

Selene Pem - Trainee Counselling Psychologist, City University, Department of Psychology, Northampton Square, EC1 OHB. Tel: Email:

Supervised by Dr Jessica Jones-Nielsen, City University, Department of Psychology, Northampton Square, EC1 OHB, Tel: Email:

What is the study about?

This study seeks to extend our understanding of the role of compassion in acute inpatients wards, in particular, to examine staff experiences of compassion working on acute inpatient wards. Research has shown that service users who have learned about compassion through ward based programmes (Compassion Focused Therapy (CFT)), experience significantly increased levels of calmness and lower levels of distress.

The studies on compassion to date have predominantly focussed on service users. However, we also know that social relationships, which are akin to staff-patient relationships, play a part in regulating our emotional system. We are interested in finding out staff members' experience of compassion and what it may look like in their daily working lives. By asking staff about their own personal experiences of compassion on the ward, it can be identified if CFT may be useful in ward training programmes.

This study will *explore staff members' individual experiences of compassion; explore what factors inhibit compassion (i.e., what gets in the way of providing high-quality compassionate care that you would like to give?), and what facilitates it (i.e., what will help you to provide the high-quality compassionate care you would like to give?).*

Who will be taking part?

To explore this we need to talk to around 6 - 8 NHS staff members from North East London Foundation Trust. I would like to talk to staff members aged 18 – 65 who have worked on acute inpatient wards for a continuous period of 12 months. Sharing your experiences will help to identify areas for staff training and development and for potential ward based programmes.

What will it involve for me?

This study will require a one off visit from the researcher who will conduct a semi-structured interview. The interview will last between 30 – 40 minutes. The visit is outlined as follows:

- Before the research is conducted you will be given this information sheet to read through and given the opportunity to ask any questions or queries you have regarding the research.

- If you are happy to take part in the study, you will be given a consent form to fill out to illustrate that you are happy to take part.

- You will be asked to complete a personal information sheet (e.g., date of birth, ethnicity, religion) which will give me more information about the people who are taking part in the study.

- You will then be asked to participate in an audio recorded interview on compassion that will last 30-40 minutes.

- Interviews will take place at your place of work at a pre-arranged time or at City University London, at your request. The researcher will be sensitive to your needs to be interviewed off-site as the research is on a work-related topic.

Will my information be kept confidential and anonymous?

All the information you give will be strictly confidential. Exceptions are that data (non-identifiable) will be made available to the field supervisor, university supervisor, and academic assessors. Nothing you discuss in this study will be passed back to your manager or supervisor. It is strictly for research purposes only.

The researcher will be required to breach confidentiality in light of any legitimate concerns of harm to self or others that arise during the interview. In such circumstances the necessary parties will be informed.

The results and any published findings will also be anonymous; your name will not be quoted. All data will be stored in a locked filing cabinet; questionnaires will be stored in a cabinet separate to personal identifiable data. All electronic data will be stored on a password protected computer which only the researcher will have access to. All data and personal information from this study will be kept for five years after the study has finished so the study can be written up for publication in a research journal as recommended by the Data Protection Act (1988).

What are the advantages and disadvantages of taking part?

Taking part in this research may also provide evidence for new psychological interventions and therefore may lead to the improvement of healthcare service in the future. You may find it an enjoyable experience being involved in such work.

It is possible that talking about your personal experiences may result in some distress. The person interviewing you will be sensitive to this as they have experience working with people who experience distressing emotions. You will have the opportunity to discuss any concerns at the end of the interview and you are free to withdraw from the process at any point.

What happens if something goes wrong?

The study does not have any 'medical' interventions. You will only be asked interview style questions. There is no 'right and wrong' to this, the study is about finding out the things that are important to you. As such there is nothing about the study that should impact on your current health.

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for

a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, then in the first instance please contact: Dr Jessica Jones-Nielsen, Clinical Director, City University, Department of Psychology, Northampton Square, EC1 OHB, Tel: Email:

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

Independent Advice

Please contact the centre below to obtain further impartial information about participating in the study.

Research & Development Department**,** North East London Foundation Trust, 1st Floor Maggie Lillie Suite, Goodmayes Hospital, Barley Lane, Ilford, Essex, 1G3 8XJ Tel-0300 555 1200

Or INVOLVE website, which is independent organization that provides advice to the general public who are thinking about taking part in research. http://www.invo.org.uk/

Remuneration

There will be no remuneration for taking part in this study.

Resources

Please find below a number of resources and telephone numbers which you may find helpful if you

feel you are experiencing any difficulties after the interview:

Samaritans (24h emergency helpline) – www.samaritans.org.uk 08457 90 90 90

SANE is one of the UK's leading charities concerned with improving the lives of everyone affected by mental illness- www.sane.org.uk

If you wish to see someone privately to discuss any problem, the following organisations have lists of qualified therapists and counsellors which can be accessed under the 'Find a therapist/psychologist' section.

www.bacp.co.uk (British Association for Counselling and Psychotherapy) 01455883316
www.psychotherapy.org.uk (UK Council for Psychotherapy – UKCP) 020 7014 9955
www.bps.org.uk (British Psychological Society) 0116 254 9568
www.babcp.org.uk (British Association for Behavioural and Cognitive Psychotherapies)

CITY UNIVERSITY LONDON

North East London NHS
NHS Foundation Trust

Mental Health Services

Title of Study: Exploring staff experiences of compassion in acute inpatient settings

DEMOGRAPHICS FORM

Participant No		**Gender**	☐ Male ☐ Female
Date of Birth	_ _ / _ _ / _ _ _ _	**Age**	
Employment Status	☐ F/T ☐ P/T ☐ Agency Staff ☐ Student ☐ Voluntary		
Profession	☐ Nurse ☐ Occupational Therapist ☐ Student Nurse/ OT		
Duration of service in:	Mental Health: Years__ Months__	Inpatient Care: Years __ Months__	

Ethnicity		
Asian/Asian British ☐Bangladeshi ☐Indian ☐Pakistani ☐Any other Asian background **Black/Black British** ☐African ☐Caribbean ☐Any other Black background	**Mixed** ☐White & Asian ☐White and Black African ☐White and Black Caribbean ☐Any other mixed background **White** ☐British ☐Irish ☐ Any other White background	**Other** ☐Chinese ☐Any other ethnic group Specify_____
Religious Beliefs		
☐ Buddhism ☐ Christianity ☐ Islam	☐ Sikhism ☐ Hinduism ☐ Judaism	☐ Atheism ☐Jainism ☐ Other, _____

CITY UNIVERSITY LONDON

North East London NHS
NHS Foundation Trust

Mental Health Services

CONSENT FORM

Client Identification Number for this study…

Title of Study: Exploring staff experiences of compassion in acute inpatient settings

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher in a one off visit • allowing an audio recording of the interview	
2.	This information will be held and processed for the following purpose(s): I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I consent to the use of sections of the audio recording to be transcribed and used in the write up of the study.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Participant	Signature	Date
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Title of Study: Exploring staff experiences of compassion in acute inpatient settings

INTERVIEW SCHEDULE (adapted from Crawford, 2014)

1. I would like to start by asking you what you understand compassion to mean. Prompt: What does the word compassion mean to you?
2. What do you see as the key qualities of a compassionate person? Prompts: What do you see as the key qualities of being compassionate? If someone was being compassionate toward someone else, what would that be like? Example of compassion if they are struggling: Compassion has been defined by the Dalai Lama as "openness to the suffering of self and others with a commitment to relieve it." Compassion can also include attentiveness, sensitivity, warmth, and kindness—but the main focus is a concern to relieve distress. So for our research we'd like to explore two aspects of compassion:
    a. First I will explore with you what you think gets in the way of you providing high-quality compassionate care for your patients in the way you would like to do so.
    b. Second I will explore what things could facilitate you in being able to provide high-quality compassionate care than you do at present.
3. What do you feel constitutes compassionate care in your area/patient group?
4. What would facilitate you in being able to provide higher quality compassionate care? Prompts:
    a. A better facility/location for you to work with your patients
    b. More flexibility with your allocated time
    c. More support from colleagues and management
    d. More autonomy within your role
    e. Better care from other professionals
5. What do you think gets in the way of your area providing high-quality compassionate care of the form you might like to provide? Prompts:
    a. What are your general feelings about your workplace?
    b. Is this facility the correct one for you to carry out your role?
    c. Are your colleagues and/or management interested in the fact that you do a good job?

d. Do you have sufficient time to undertake your role satisfactorily?
e. Are you pressured to do too many other tasks and thereby unable to do your job as well as possible?

6. Is there anything you feel we haven't talked about today that you would like to add?

North East London NHS
NHS Foundation Trust

Date: 11th September 2014

Dear Selene Pem,

Re: R&D ref no 2353 – Exploring staff experiences of compassion in acute inpatient settings

I am pleased to inform you that the above named study has been granted approval and indemnity by Professor Martin Orrell, Director of Research and Development North East London NHS Foundation Trust. You must act in accordance with the North East London NHS Foundation Trust's policies and procedures, which are available to you upon request, and the Research Governance Framework. Should any untoward events occur, it is **essential** that you contact your Trust supervisor and the Research and Development Office immediately. If patients or staff are involved in an incident, you should also contact the Governance and Assurance department, in Goodmayes Hospital, and complete the Incident and Reporting Form, namely the IR1 form.

This approval is valid until 1st August 2015. You must inform the Research and Development Office if your project is amended and you need to re-submit it to the ethics committee, if your project is extended or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records.

You are also required to inform the Research and Development Office of any changes to the research team membership, or any changes in the circumstances of investigators that may have an impact on their suitability to conduct research.

Yours sincerely,

Research and Development Manager, North East London NHS Foundation Trust

CITY UNIVERSITY LONDON

9th September 2014 Dear Selene Pem,

Reference: PSYETH(UPTD) 13/14 74
Project title: Exploring staff experiences of compassion in acute inpatient settings.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed (c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee , in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch. Kind regards,

Psychology Research Ethics Committee School of Social Sciences
City University London
London EC1R 0JD

Secretary

Chair

North East London NHS
NHS Foundation Trust

Research and Development Department
1st Floor Maggie Lilley Suite
Goodmayes Hospital,
Barley Lane,
Goodmayes, Essex.
IG3 8XJ.

RESEARCH AND DEVELOPMENT DEPARTMENT

PEER REVIEW FORM

Project Title:
Exploring staff experiences of compassion in acute inpatient settings
Person completing form: Oliver Mason
Job title: Deputy Director of Research and Development

1) **Appropriateness** (potential to benefit patients, clinical services, clinical science)

The study seeks to explore staff experiences of compassion and how it may related to their work in inpatient settings. This is an appropriate area of relevance to clinical services.

2) **Resource Implications** (Feasibility and realistic timescales and costings. Implications following completion of research.)

Few if any resource implications as this requires a small amount of time from 6-8 staff.

3) **Research Design** (Validity of the proposed research methodology, completeness and presentation of the proposal, quality of research design.)

A valid methodology. The proposal contains an outline of the interview to be used and the analysis to be conducted on the data.

4) **Legal Liability**

Patients are not involved. There is no intervention or invasive procedure of any sort and no liability issues of note.

5) Competence of research team (Researcher, supervisor and collaborators.)

The supervisor is a researcher at City University and the researcher is a trainee counselling psychologist who is appropriately competent to conduct the study.

6) Proper accounting for money from pharmaceutical companies.
NA

7) Other Comments
The study title for the PIS is inaccurate.

Date: 28.8.14 **Signature:**

Please return this form to

Research and Development Department
1st Floor Maggie Lilley Suite
Goodmayes Hospital,
Barley Lane,
Goodmayes, Essex.
IG3 8XJ.

For queries please contact

Appendix 8: Emergent themes for Paul (Participant 28)

Cluster	**Theme**	**Page and line number**	**Quote/Keyword**
Perspectives of compassion; the ideal	Understanding the other	P1, L3	**Putting yourself** in the service users shoes
Putting myself in your shoes	Understanding the other	P1, L9	I think compassion also entails listening **understanding**
	Understanding the other	P1, L14	But you need to realise that these people have mental illness
	Understanding the other	P1, L23	Because if you can't **put yourself in someone shoes** …you can't walk their walk
Showing you I'm there…moving towards you	Advocating for patients	P1, L29	Could you speak on my behalf…which I've always tried to do
	Going that extra mile	**P2, L41**	If I wasn't a compassionate person …I would be like 'come on its food' but here **you actually go out of your way to resolve things**
	Going that extra mile	**P2, L49**	Giving them information that might be required

	Going that extra mile	**P2, L46**	I think it is being **proactive**
The Conflict Within; Inhibitors of Compassion			
Leaning away from you	Avoidance	**P5, L168**	I feel very uncomfortable being out there …you don't want to go to his room or anything like that
	Avoidance	**P5, L169**	I totally keep my **distance**
	Not engaging	**P5, 170**	I **don't** really want to **engage** with them unless I have to
	Avoidance strategies	**P5, L176**	He may have an issue or something which is why it's better to **hand it over**
	Avoidance strategies	**P5, 181**	Yes it has kind of died down but I was seriously considering **cancelling my shifts**
	Avoidance	**P6, 198**	You tend to keep a bit of distance …even staff …you notice staff **avoiding** him And I feel …and you can understand where they're coming from
	Not engaging	**P6, L213**	I mean obviously I will meet their basic needs like if they need

			medication and stuff …other than that **I will refuse to just engage** with them and say sorry the way you spoke to me I don't feel comfortable
	Avoidance	**P3, L92**	Especially if it's racist I tend to keep my **distance**
Difficult Emotions	**Feeling afraid**	**P3, L100**	You are extremely cautious around them
	Feeling afraid	**P4, L140**	There is always a **fear** that things will escalate
	Feeling afraid	**P5 , L155**	**And every time he comes into the office I kind of turn my gaze a lot …and avoid eye contact alot**
	Uncomfortable feelings	**P6, L171**	**I had to ask someone to go with me...There was no way I was doing a depot…I made it clear**
	Feeling hurt	**P6, L212**	**I will say actually refused to engage with them so they know that I'm human as well. I have got feelings ….**

Responsibility - the buck stops with me	Unfair responsibility	**P10, L349**	And if they find out that the person was drug screened, and then they find out who let that patient out, who made the decision, And I tend to notice that the **buck stops with the nurse.** And there's one thing that astonishes me because the consultant will never accept **responsibility**

Appendix 9: Transcript sample for Maya (Participant 4)

REDACTED

Appendix 10: Reflective diary sample for Maya (Participant 4)

REDACTED

SECTION C

PUBLISHABLE PAPER

REDACTED