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ORIGINAL ARTICLE

Discourses of compassion from the margins of health care: the perspectives and experiences of people with a mental health condition

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ABSTRACT

Background: Evidence supports the positive influence of compassion on care experiences and health outcomes. However, there is limited understanding regarding how compassion is identified by people with lived experience of mental health care.

Aim: To explore the views and experiences of compassion from people who have lived experience of mental health.

Methods: Participants with a self-reported mental health condition and lived experience of mental health ($n = 10$) were interviewed in a community setting. Characteristics of compassion were identified using an interpretative description approach.

Results: Study participants identified compassion as comprised three key components; 'the compassionate virtues of the healthcare professional', which informs 'compassionate engagement', creating a 'compassionate relational space and the patient's felt-sense response'. When all these elements were in place, enhanced recovery and healing was felt to be possible. Without the experience of compassion, mental health could be adversely affected, exacerbating mental health conditions, and leading to detachment from engaging with health services.

Conclusions: The experience of compassion mobilises hope and promotes recovery. Health care policymakers and organisations must ensure services are structured to provide space and time for compassion to flourish. It is imperative that all staff are provided with training so that compassion can be acquired and developed.

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Introduction

Over a lifetime, it is estimated that approximately 29% of the global population will live with at least one clinically diagnosed mental health condition (Murray et al., 2020; Nochaiwong et al., 2021). Reports indicate this number may increase as a result of the Covid-19 pandemic (Pierce et al., 2020). Mental health is known to occur on a continuum (Johnstone & Boyle, 2018) and various difficulties are believed to be caused by life experiences, rather than purely biological (Alegría et al., 2018; Johnstone, 2019; Rose, 2018). Hence, there is international momentum for less medicalised approaches to improving the health outcomes of this population (Double, 2019; Gilbert, 2010; Spandler & Poursanidou, 2019; Von Peter et al., 2019).

In the last decade, policymakers have recognised compassion as core to quality health care (Department of Health, 2012; NHS England, 2018) and expectations for compassion in health care settings have increased from patients, families, and society (Maxwell, 2017). This is supported by a growing body of evidence which emphasises the positive influence of compassion on peoples' experiences of care (Kang et al., 2018; Kirby, 2017; Sinclair et al., 2016; Trzeciak et al., 2019). A perceived absence of compassion can have a profoundly negative impact on patient care (Frampton et al., 2013; Francis, 2010, 2013). It is therefore important to consider how compassion might be employed within health care provision more broadly. However, it has been recognised that clinicians often experience challenges to delivering compassionate care due to excessive workloads (West et al., 2020). Typically, compassion in the workplace is known to improve team culture (Scarlet et al., 2017) which can have lasting positive effects on the wellbeing of health care professionals (HCPs). In addition to helping individuals who access services, compassionate cultures may be fundamental to improving patient satisfaction and the overall standards of care (Ross et al., 2012).

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Compassion is grounded in the recognition of the suffering of another person and the action taken to relieve and prevent suffering (Sinclair et al., 2016). In mental health settings, compassion is considered core to the development of the therapeutic relationship[1] (Stickley & Freshwater, 2006). This relationship is vital as it allows the HCP to contain distress in a psychologically safe space which facilitates growth (McAllister et al., 2019), enabling recovery through meaningful interactions (Ellison & Sami, 2014; Spandler & Stickley, 2011). However, connecting therapeutically is regularly confounded by the acute and often withdrawn mental states of people who experience mental health difficulties (Felton et al., 2018). Acute psychological distress causes fear which can manifest in violent and aggressive behaviours (Bowers et al., 2012; Sweeney et al., 2015). These behaviours are more common in mental health environments compared to other areas of health care and are known to cause distress to HCPs (Power et al., 2020), thereby inhibiting the emotions involved in caring work, including compassion (Zhang et al., 2018). Legislative reforms in mental health promote a 'least restrictive approach' to the management of these behaviours (Department of Health, 2014; Sustere & Tarpey, 2019). Thus, the relational aspects of care have become increasingly important.

Compassion is considered relational in the sense that it has been identified as a response to suffering whereby the HCP feels (within themselves) for the suffering of the other person. This is then expressed virtuously from HCP to the person receiving care (Sinclair et al., 2016). It is argued that when care occurs 'with' the person this enables health outcomes to be enhanced through the development of positive relationships (Stacey et al., 2016). The theoretical basis of caring 'with' a person, through interpersonal relating, is grounded within Rogerian theory (1951, 1963) and the understanding that a person-centred approach enables therapeutic work to be undertaken. If a trusting relationship can be developed between HCP-patient/client in a way which focusses first and foremost on the patient/client then healing is believed to be made possible (Tolan & Cameron, 2016).

The skills required for interpersonal communication and person-centred working are considered necessary for the practice of mental health care generally (Hamovitch et al., 2018; Stickley & Freshwater, 2006). In addition, this approach is believed to be useful for balancing the power differential in mental health (Mercer, 2015). The latter is of particular importance for those with mental health conditions who frequently experience marginalisation as a result of structural inequalities in society (Blanchet Garneau et al., 2019; Hui et al., 2021; Huggett et al., 2018). Thus, an interpersonal and collaborative approach to alleviating distress is essential (Lloyd & Carson, 2011).

Despite the apparent necessity of compassion to quality care, the pervasive usage of the term throughout the literature, and the focus on compassion within major health care reforms, an understanding based upon the perspectives of people with lived experience of mental health care is lacking. The current study goes some way to redress this by exploring compassion from the perspective of individuals who have lived experience of mental health.

Methods

Study design

This qualitative study was grounded in interpretative description, as outlined by Thorne (2016). This approach is based on inductive reasoning where observations lead to broader generalisations (Thorne, 2008). The investigator, therefore, seeks to engage with the data and look beyond what is assumed; to find relationships and patterns, in order to make suggestions about how the object of inquiry might be encountered in the future. Hence, interpretative description was considered appropriate as we were guided by the need to understand compassion in relation to the context, and to generate knowledge that could inform clinical practice. The practical and theoretical foreknowledge of the research team is considered a strength of this type of inquiry (Hunt, 2009). Our team comprised individuals from diverse clinical and educational backgrounds (mental health nurses; educators; lived-experience advisor) which is considered to help reduce confirmation bias (Johnson et al., 2020).

Participants

Ten ($n = 10$) participants were recruited via a community mental health organisation in England. A lived-experience advisor also promoted the study via their own networks. Inclusion criteria were current self-reported mental health condition; current or prior user of statutory mental health services; aged over 16 years; fluent in English; willing to share experience of restrictive practices and/or hospitalisation under the Mental Health Act (2007).[2] Exclusion criteria were self-reported current mental health crisis. Details of participants characteristics are provided in Table 1.

Ethics

Ethical approval was obtained (Coventry & Warwick Research Ethics Committee, Ref: 218630), and all participants gave written informed consent. All participants received information with details of mental health support services and optional follow-up phone calls were offered. The use of pseudonyms ensured anonymity.

Data collection

Face-to-face, individual, open interviews were conducted (lead author) between November and December 2021. Interviews lasted between 37 and 113 min (average 57 min).

[1]The therapeutic relationship refers to the relationship between HCP and client. It's how the HCP and client engage, with the hope of bringing about a beneficial change for the client (Bordin, 1979).

[2]The Mental Health Act (2007) is the legislation that covers the assessment, treatment, and rights of people with mental health conditions.

Table 1. Participant characteristics.

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

Table 2. The key components and features of compassion identified by study participants.

Key component	Features	Description
Compassionate virtues of the health care professional	Warm	HCP displays a warm and calm demeanor
	Calm	
	Authentic/Genuine	HCP presents authentic self during interactions
	Honest	
	Non-judgemental	Judgemental attitudes were reported to be antithetical to compassion
Compassionate engagement	Uses communication skills to understand patient/client in the context of their life	HCP employs active listening to convey a sense of genuine care for the person
	Trauma-informed care	Recognition that many people have lived experience of prior trauma
		HCP considers 'what happened to you' rather than 'what's wrong with you'
Compassionate relational space and patient's felt-sense response	Connection on a human–human level	The focus is first and foremost on the patient/client
	Validation and non-judgment	A judgemental approach was felt to be damaging to mental wellbeing

The presence of printed prompts/questions (Supplementary Appendix) offered participants a focus and/or guide to draw upon during the interview. Summary notes were made with participants at the end of each interview to verify any emergent themes.

Data analysis

The lead author began the analysis by listening to the audio-recordings multiple times while transcribing. This enabled reflection on the conversations with participants. Transcripts were returned to participants for review. No issues were raised. Draft themes emerged and evolved through the repeated reading of transcripts and comparison with interview summary notes. Initial themes were refined through discussion with co-investigators and through the writing-up process. Once finalised, themes were returned to study participants for comment. Study participants' feedback concurred with the derived themes. This approach aimed to enhance reliability and trustworthiness in the results (Noble & Smith, 2015). The lead author and co-investigators reviewed the final themes. This process resulted in a high level of agreement.

Results

Compassion was identified at the individual level of interaction in the context of the HCP-patient/client relationship and was articulated as three key intersecting components. These were 'the compassionate virtues of the HCP', which informs 'compassionate engagement', creating a 'compassionate relational space & the patient's felt-sense response'. Each component comprised several features which are shown in Table 2. Verbatim quotes shown in the following sections exemplify the components of compassion identified by study participants (emphasis in speech is shown in **bold**).

Compassionate virtues of the health care professional

Study participants identified compassion as centred around the HCPs' virtues independent of a patient/client's behaviour, or ways in which the patient/client's distress was expressed. Virtues were listed as warm, calm, authentic/genuine, honest, and non-judgemental and were felt to be embodied in the individual characteristic traits of the person delivering care. For participants, virtues functioned as prerequisites to individual behaviours and expressions of compassion.

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

> She was really calm, understanding and warm, and just listened; I think that is a really big part of it - she didn't just make assumptions - she actually listened. Erm so that stuck out as a huge moment for me. (Lilly)

A compassionate HCP was described as someone who displays a warm and calm demeanor. Someone who embodied these traits was perceived as trustworthy, which was viewed as especially helpful when someone is feeling unwell.

Compassionate engagement

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

Seeking to understand – active listening

For compassion to flow, the HCP needed to combine virtues with the skill of active listening. Listening was felt to be more than just allowing the person to speak.

> There is a total difference between a person who listens and a person who **hears**. (Kevin)

There was an active element to listening which enabled them (patient and/or client) to feel compassion, and to provide a sense that the professional was trying to understand the person's unique perspective and experiences.

> It is **trying** to get alongside somebody and **try** and … .you can't understand how somebody felt because you can't get in their head. But you can listen and relate to them by what they are saying. I think they call it active listening or something like that. (Zoe)

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

Listening was perceived as a skill utilised by the HCP which provided the space for them to seek to understand the patient/client. However, as Sara's quote illustrates, for this to be compassionate, it should be done in a non-judgemental way.

Compassionate (and non-compassionate) engagement

Participants provided various examples of clinical encounters of what they described as 'non-compassion'. These examples illustrated how HCP had not paid attention to what was needed (or not needed). It was felt that being mindful of someone's basic needs was an important part of the interpersonal interaction, and crucial in terms of recovery.

> On one occasion I was on an in-patient ward, and I was very poorly. I had tried to take my own life, and I ended up in high dependency because I drank weed killer. They got me back to my own psychiatric ward and then the OTs came the next morning after I got back and insisted that I should go to OT. I was in no fit state to do anything like that, I was physically and mentally in a terrible state … . That was a **big** non compassion, inconsideration about my state at that time. (Zoe)

John (below) shared two examples of two different clinical encounters. In both encounters he had felt judged by the HCP, which exacerbated his already declining mental health, so much so that he was left feeling worthless and attempted to end his life immediately after the interaction.

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

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

The above quotes from John are clear examples of actions and/or behaviours expressed by the HCP which lack compassion. Participants *ideally* wanted to receive care from someone who 'genuinely' showed an interest in them, and could easily distinguish a compassionate HCP from a non-compassionate HCP.

> I have come across somebody who … we have got into these very deep conversations, only to find out that they have made some real assumptions about what I could cope with, what I could do, or what life was like for me, and it is almost like they painted me as this particular picture with the tragedy music, and that was my personal soundtrack. That wasn't helpful to me. (Sara)

For Sarah, compassionate engagement meant being given choice and control. She recalled having been detained by the police following attempted suicide; experiences were validated, and agency and autonomy were honoured.

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

Sara was very clear that this was a good example of compassionate engagement. The policewoman displayed the virtues of compassion. The policewoman was honest, accepting, and authentic. The quality of the interaction was evident, and as a result, despite being in a vulnerable situation, Sara expressed having felt safe. "*I felt really safe, it did feel safe though even though I was with the police. I felt really safe with her in particular*".

Trauma-informed care and (re)traumatisation

Participants expected that care would be person-centred and acknowledge that people who access services often have past

trauma(s). However, the absence of a trauma-informed[3] approach to care was prominent in participants' accounts. Sarah felt that mental health practitioners needed more training.

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

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

> Trauma work is very different because you are not dealing with one or two incidences, you are dealing with 40 years' worth of multiple trauma upon trauma, upon trauma … .So, you are going through quite a lot and it's really hard to go through. It's really hard work, obviously the ideal outcome is that it is positive because your life is better, you are either recovered or you are certainly better than you were. But it's so hard to go through and then to feel like it was a waste of time, like that has created more trauma for you really without a positive outcome. (Mary)

A trauma-informed approach to care was believed to be a compassionate way of working with patients/clients in this context. This was interconnected with seeking to understand the person in the context of their life. Study participants' felt this involved getting to know the person and seeing the person as 'more than' their mental health difficulty or condition.

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

HCPs were regarded as compassionate when they were perceived to be looking beyond a person's mental health difficulty, and to focus first and foremost on the person instead of their diagnosis.

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

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

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

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

Clearly, for study participants compassion was crucial and tied up with the relational aspects of caring, including the co-creation of care planning.

Participants described how individuals who work in psychiatry often have negative attitudes towards the people in their care. Participants felt this caused additional (re)traumatisation and systemic stigma through the perpetuation of these attitudes and associated negative language. Connected to this was the biomedical knowledge of psychiatric classifications and the way in which interpretations of mental health can delegitimise peoples' lived experiences.

> You are just adding more trauma aren't you if you classify people as PDs[4] and stuff like that. Or like 'oh they are all mental'. I just think well if you find it so difficult when you're in charge of vulnerable people then why don't you just get a different job? If you have to categorise people in such a way, then you probably shouldn't be working with vulnerable people. It's still their experience, and there are so many people that are traumatised on the wards. (Lilly)

Lilly implies that working with vulnerable people requires a particular attitude. The attitudes, behaviours, and negative language (which may touch on old traumas) used around certain diagnoses caused distress to patients. Again, this was said to be destructive and had implications for mental wellbeing.

Chloe described the coercion and force experienced during her care and treatment which caused significant (re)traumatisation.

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

The damage to Chloe's mental state while being treated in mental health services was expressed throughout the interview. In Chloe's view, the harmful experiences were the result of biomedical dominance and a lack of knowledge and support for trauma-informed care.

Compassionate relational space and the patient's felt-sense response

Participants discerned a compassionate HCP based on how the HCP made them feel when interacting. This was described as an interpersonal connection or a relational space. Hence, the core component of compassion was underpinned by the HCP's virtues (of compassion) and

[3]Researchers and policymakers increasingly recognise that adverse childhood events (ACE) can cause trauma and impact adult mental health. The ACE framework provides a guide for early interventions with the aim of mitigating suffering in the future (Parliament UK, 2018).

[4]PD is an abbreviation used to refer to people with a diagnosis of 'Personality Disorder'. Attitudes towards people with Personality Disorder have been shown to be generally negative (McKenzie et al., 2022).

conveyed at point of interpersonal connection, which, in effect, created a compassionate space. Study participants described how a compassionate response (for the patient) was combined with seeking to understand them (patient) as a person.

> For me compassion is about how people make you feel, and kindness. Treating you as a real person and taking time to think what is right for this person, and knowing that that might change as things change, and as their conditions change and fluctuate. (Jane)

In order to meet the threshold of compassion, participants felt that the HCP needed to make a conscious effort to relate to them as a fellow human being. For study participants, compassion existed within a relational space, and with the correct conditions present, which enabled compassion to be externalised by the HCP. This was achieved when the HCP employed the skills of active listening.

Validation and non-judgment

Study participants described 'ideal' compassionate engagement as the HCP actively listening in a non-judgmental way. Across participants, active listening and validation of experiences were considered essential to compassion. Unfortunately, many examples were articulated where the HCP had used the information, elicited in the process of active listening, to judge, discriminate, and make assumptions. This was considered antithetical to compassion.

> That's where compassion comes in – appreciating that everyone is different and considering the different levels of understanding that people have and behaving accordingly. Don't just assume or patronise me. (Zoe)

A judgemental approach was felt to be particularly damaging to mental wellbeing.

> Right at the start she had already accused me of something that I hadn't done and then dismissed anything that I gave her, so she immediately devalued me, and my self-worth was made to feel even less than it already was, which I now recognise but my self-worth and my self-esteem were very low for various reasons, and she was just perpetuating **that**. She was making that even worse than it already was. (Anna)

Without the experience of compassion, Lily and Anna felt that their mental health would be adversely affected, and they became detached from engaging with health services.

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

> I had literally put myself out there, very vulnerable and met with this hideous response which made me feel, wow, I need to close down, close down. (Anna)

Study participants reported clearly that when compassion was experienced, healing and recovery were felt to be possible through the mobilisation of hope, confidence, and trust.

> That's what everything comes down to … if someone is there and they are compassionate that can be just so healing you know. (Lilly)

Study participants expressed the importance and desire to receive compassion. It was believed that when HCPs had time and space to express compassion it was felt to have enduring therapeutic effects for patients.

Discussion

Several studies have reported that compassion can have a positive influence on health and wellbeing in a range of populations (Kang et al., 2018; Kirby, 2017). In mental health, research has indicated that when compassion-based interventions are employed there are significant improvements in outcomes for an array of conditions (Gilbert, 2010; Rooney, 2020). However, a review of the literature for the current study revealed a paucity of evidence regarding how compassion is identified from the first-person perspective of those with lived experience of mental health care. Given the complexities of the expression of distress in mental health (Bowers et al., 2012; Sweeney et al., 2015), it is important to appreciate how compassion is understood in this context.

A notable finding of the current study was the identification of HCPs' virtues as antecedents to compassion. Several virtues were identified which, when expressed by the HCP, demonstrated a compassionate response (of the HCP) to mental distress. This response was reported to be strengthened when the HCP 'tries to understand' the person in the context of their life and experiences are validated – irrespective of the patient/client's presenting behaviours. This affirms studies within the field of physical health care in which compassion has been defined as '*a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action*' (Sinclair et al., 2016). Where it was felt that the HCP conveyed preconceived ideas or passed judgment, this had a negative impact on mental health. Participants of the current study were clear that compassion had the power to heal but felt more education was needed in terms of understanding the effects of trauma on mental wellbeing. This aligns with international scholarship regarding the development of trauma-informed care and the need for services to acknowledge the changes necessary to reduce iatrogenic harm in psychiatric environments (see Sweeney & Taggart, 2018). Hence, compassion is not just simply responding to acute suffering, but it is having the foreknowledge or forethought about how to mitigate suffering in the future. It is deeply in the present moment, but with an appreciation of the person's past and an eye on the horizon.

It has been recommended that compassion takes precedence across all statutory health care services (Department of Health, 2012; NHS England, 2018). This may be useful for improving occurrences of future mental health conditions (Murray et al., 2020). However, in psychiatry, biomedical dominance, the pathologisation of lived experiences, and damage to mental health reported by participants points to a lack of knowledge around trauma-informed care (see

Isobel et al., 2021). It may be pertinent therefore to consider upskilling those who work in psychiatry to improve relationships and environments for both staff and patients/clients alike (Felton et al., 2018). In turn, this may improve the experience of compassion for those receiving care.

Participants of the current study described both the virtues and active listening skills utilised by HCPs as a way of enacting compassion. As Stickley and Freshwater (2006) have asserted, these virtues and skills are recognised as essential to mental health care. Moreover, the attributes, behaviours, and clinical skills noted here are foundational the training offered to counsellors of the Rogerian person-centred approach (1951, 1963). Rogers believed these skills and virtues can be learned and developed. Likewise, scholars who have progressed Rogers (1951, 1963) work assert that skills such as active listening and interpersonal communication can be taught (Hamovitch et al., 2018; Stickley & Freshwater, 2006; Tolan & Cameron, 2016). Ideally, HCPs should learn the virtues associated with compassion. However, if they cannot develop those virtues, then the skills of active listening and non-judgement may be a way in which the experience of compassion can be enhanced for people with lived experience of mental health. As such, it is our recommendation that staff at all levels working within mental health services be trained in these areas. The more this approach is adopted in general, the greater the chances are that the needs of patients/clients will be met, leading to a fundamental increase in compassion.

The experiential knowledge presented in this paper indicates that there is a significant lack of compassion within mental health services. Despite having been espoused as an indicator of high-quality care for all (Mitchell et al., 2017; Public Health England, 2015), previous research has highlighted insufficient time for HCPs to enact compassion, which is systemic in the structure of care services in the UK NHS (Crawford et al., 2014). The increasing administrative burden on HCPs has also been reported (West et al., 2020). Studies such as the one presented here are therefore important for informing future policy regarding system-wide changes that are required if the advantages of compassion for inducing positive health and wellbeing are to be realised.

Strengths and limitations

This study has several strengths. Firstly, our interview data has revealed a wealth of information relating to compassion in the context of mental health care and treatment. The authenticity of these accounts contributes to the perceived genuineness which allows for better understanding of participants' individual and collective lived-experience. As far as we know, this is the first study to utilise the discourses of people with lived experience of mental health care to identify compassion. Lastly, our research team consisted of a group of individuals from varied clinical and educational backgrounds (mental health nurses; educators; lived-experience advisor). While we accept that eliminating all sources of bias may be impossible in qualitative research, this diversity within the research team goes some way to mitigating this.

This study has some limitations. Those who identify as being from ethnic minority backgrounds may not identify compassion in the same way in the context we studied. To maximise transferability, accounts from an ethnically diverse sample should be presented. Our small, largely female sample also limits generalisability of the results. Irrespective of these limitations, findings offer preliminary insight into how compassion is identified in mental health and the positive influence of compassion in this context.

Conclusion

When people with a mental health condition experience compassion it mobilises hope, promotes healing and is beneficial to recovery. There is a need for staff at all levels of service provision to be upskilled regarding the attributes, behaviours, and clinical skills associated with the experience of compassion. Training will enable more of the health care workforce to adopt and develop the principles of compassion from the perspectives of those who receive care.

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