Mental Health Nurses' Constructions of Compassion: A Discourse Analysis

ABSTRACT

Compassion is an important element of contemporary nursing work. Compassion has been recognised as necessary for improving health outcomes. However, very little is known about how compassion is understood in the mental health practice setting. We conducted interviews with seven mental health nurses to explore their perspectives on compassion, and views on compassion policy. Analysis of the data revealed that compassion was identified and discussed as '*Compassion as part of the person (and the profession)*; *Compassion: Fundamental to the nursing role*; *Barriers to compassion*; *Perspectives on compassion policy*. In addition, findings demonstrated ethical constraints on compassion in the mental health context, as well as the administrative burden on nurses more broadly, which was also a reported barrier to compassion. Mental health nurses identified compassion as fundamental to their clinical practice, yet compassion was impeded owing to practical and emotional constraints upon nurses. System-wide action must be taken to increase and support the mental health nursing workforce to strengthen the practice of compassion. This will be fundamental to improving health outcomes that are claimed to be enhanced by compassion. This study is reported according to the COREQ guidelines.

KEY WORDS: *compassion; perspectives; discourse; mental health nursing*

Words: 5879 (- quotes, abstract, references and tables) = 3501

INTRODUCTION

In the context of mental health, evidence suggests that compassion can influence patient wellbeing and improve health outcomes (Gilbert, 2010; Hammarström *et al.,* 2020). Research has indicated that when care is underpinned by compassion, there is improved adherence to medications (Lown *et al.,* 2011), increased patient satisfaction (Taylor *et al.,* 2019), and enhanced wellbeing (Sinclair *et al.,* 2016). Compassion has been defined as embodied by the healthcare professionals' need to be sensitive to the suffering of another person - combined with the desire to relieve suffering and help that person achieve wellbeing (Gilbert, 2017; Perez-Bret *et al.,* 2016; Sinclair *et al.,* 2018; Strauss *et al.,* 2016; Younas & Maddigan, 2019). As a response to suffering, compassion is said to be engendered by the virtues of the healthcare professional, which can facilitate improved health outcomes (Brito-Pons & Librada-Flores, 2018; Sinclair et al., 2016, 2018). These positive effects of compassion on patient outcomes have made compassion a concept of interest in healthcare.

While the importance of compassion to nursing has been well documented (Babaei & Taleghani, 2019; Bramley & Matiti, 2014; Crawford *et al.,* 2013; Ferraz *et al.,* 2020; Ortega-Galán *et al.,* 2021; Sinclair *et al.,* 2016), the research on compassion in 'mental health' is underrepresented (Barron *et al.,* 2017; Gerace, 2020). The 'psychological' distress people experience in mental health is often less obvious than in physical health and can be much more complicated to understand (Stickley & Sandler, 2013). When people become mentally unwell, they often feel frightened and vulnerable (Sweeney *et al.,* 2015). This can lead to high incidences of aggression from patients compared with other areas of nursing (Renwick *et al.,* 2019). These challenging working environments are known to negatively impact on the wellbeing of mental health nurses (Power *et al.,* 2020). Hence, treating people with compassion and developing trust is considered crucial to the safe delivery of mental health care (Crawford *et al.,* 2013; Proctor *et al.,* 2013). The current study was conducted to provide insight into mental health nurses' perspectives on compassion in their clinical practice.

BACKGROUND

In the last decade, the United Kingdom (UK) government established a shared vision for compassion in healthcare, including mental health (Department of Health, 2011, 2015). This was presented at the time of a global financial crisis (Boyle, 2013), and when the UK National Health Service (NHS) was subject to numerous reforms including retrenchment, privatisation, and the decommissioning of services (de Zulueta, 2016; Kerasidou, 2019). Nursing scholars have asserted that the rhetoric on compassion was a ploy from government to improve healthcare in the UK, by adopting a simple cost-free solution to systemic issues (Tierney *et al.,* 2018). More recently, it has been argued that the foregrounding of compassion has detracted from the realities of nursing work (Chaney, 2020), and the need to confront the challenges associated with the rise of neoliberalism (Pownall, 2013)[1]. These system-based issues cause prolonged and excessive workloads which negatively impacts the wellbeing of healthcare professionals. This has a detrimental effect of staffs' ability to maintain the ability to deliver compassionate care (West *et al.,* 2021).

Contemporary mental healthcare practice involves the balancing of austerity measures [anonymised for peer review], with professional accountability and a growing 'recovery' narrative (in mental health) orientated toward the clinical cultivation of hope and compassion (Spandler & Stickley, 2011). Given the potential worldwide increase in mental health problems (Mari & Oquendo, 2020), and the reported positive impact of compassion on health outcomes (Gilbert, 2010; Hammarström *et al.,* 2020; Sinclair *et al.,* 2016), mental health nurses have increased responsibility to enact compassion in the clinical context. Hence, it is important to gain insight into their perspectives on compassion; and understand the challenges and perceived barriers to the delivery of compassionate care in mental health.

DESIGN

The aim of this qualitative study was to explore how compassion is discursively constructed by mental health nurses and to understand the challenges and barriers to compassion in this

[1] Please see Ramon (2008) for a background introduction/overview of neoliberalism and the impact of this the mental health system in the UK. Brown & Baker (2012) also offer interesting insights regarding health policy under neoliberalism.

context. Packs containing information about the study were distributed to a large mental health NHS organisation in England. Ethical approval to conduct the study was granted by the Health Research Authority [HRA] and [anonymised] Human Ethics Research Committee on 24th June 2020 [Ref: 218630].

Materials

In addition to demographic information [Table 1] the interview schedule included three key open-ended questions which intended to explore mental health nurses' experiences and perspectives on compassion in their everyday practice. These were: *"What are your thoughts about compassion in the context of mental health care?"; "How do you consider yourself to be a compassionate practitioner?"; "What do you think about compassion policy?".* Follow-up questions were asked to affirm thinking, clarify points, or to request participants develop their answer.

[Table 1]

Data collection

Telephone interviews were conducted with seven (*n* = 7) participants between October and November 2020. Interviews were audio recorded and transcribed verbatim [first author]. The researcher and participants were not known to each other prior to the interview. Before the recording started, the researcher explained the aim of the research and the processes involved in collection and storage of data. Reassurances were provided relating to confidentiality and the anonymisation of data. The purpose of this was to make participants feel comfortable during the interview and so that the interview could continue in a conversational style. Interviews took between 35-90 minutes.

Data analysis

Data were analysed according to Willig's (2008) [Table 2] discourse analytical approach. This approach is useful in elucidating discursive accounts and experiences; prompting the analyst to compare and contrast participant accounts; encouraging comparison with the wider discourses on compassion. It is pertinent to note here that, given the lack of consensus on the reporting findings of discourse analysis, coding was organised into themes. This approach is recognised

within the existing discourse studies literature (Arribas-Ayllon & Walkerdine, 2008; Greckhamer & Cilesiz, 2014).

Initial coding was undertaken by the first author, using NVivo 12 [software] (QSR International, 2018). Recordings were listened to multiple times and transcripts were read and re-read, permitting reflection on the conversations with participants. This immersion with the data facilitated the identification of emerging findings (Tracy, 2010). These initial 'draft' themes evolved through discussion with the co-investigators. Themes were refined through the process of writing up [first author] and checked for clarity and consistency with the remaining research team. The following verbatim quotes serve as examples of the themes and sub-themes associated with the core components of compassion identified by participants. The COREQ checklist (Tong *et al.,* 2007) was used to ensure a robust approach to the analysis and reporting of the study.

[Table 2]

RESULTS

Four main themes emerged regarding how mental health nurses understand compassion, and how they consider themselves as compassionate practitioners. These were: (1) Compassion as part of the person (and the profession), (2) Compassion: Fundamental to the nursing role, (3) Barriers to compassion, (4) Perspectives on compassion policy. Theme two comprised one sub-theme, 'Compassion: Experienced through the therapeutic relationship'. Theme three comprised two sub-themes, 'Ethical constraints on compassion' and 'Administrative burden: A barrier to compassion'.

Theme 1: Compassion as part of the person (and the profession)

Participants identified compassion as an inherent trait, as something that is instinctive.

"I think it just comes natural to be quite honest" (SN, ward-based - male)

"Definitely I just think it is just something that comes naturally, yeah. It's intertwined with all the other things that I do" (CN – female)

A compassionate nurse was perceived as someone who seeks to understand another person and seeks to 'try' and understand patients' distress. This was described as internally driven.

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

Participants found it difficult to separate the personal [compassionate] self from the self as compassionate professional.

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

Participants reported feeling that, compassion was integral to the professional identity of mental health nurses; and was a major driver for participants in their desire to becoming a mental health nurse.

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

Other participants were clear in referring to compassion as a distinct component of the nursing profession in general.

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

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

Compassion was viewed as a key driver in joining the mental health nursing workforce. One participant recalled having been taught compassion as a student nurse, and felt it was not necessary because it was already a part of who they were as a person.

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

Theme 2: Compassion: Fundamental to the nursing role

The interview data uncovered clear discursive constructions of compassion as being distinct to the professional repertoire of mental health nurses.

"You just do it, in everything that you have to implement" (SN, ward-based – male)

When asked to share their thoughts regarding how they considered themselves to be compassionate practitioners, participants instinctively drew upon aspects of the self - associated with nursing; driven by a caring motivation.

"In my role obviously, I meet a lot of people in quite acute distress …at times it can be difficult but you need that motivation to be caring and supporting and I think that if you don't have that, you're not gonna be able to continue to work with people in such acute distress" (SN – ward-based – female)

This viewpoint was communicated by other participants, who agreed that it would be difficult to be in mental health nursing if there were not an inherent motivation to want to relieve distress. To do this, nurses needed to understand the person within the context of their lived experiences, connecting with them on a human level.

2.1 Compassion: Experienced through the therapeutic relationship

For care to be compassionate, meaningful engagement was needed (between nurse-patient); this was discussed as central to the development of the therapeutic relationship (TR)[2]. Seeking to understand the source of someone's distress was viewed as essential to the mental health nursing role.

"A large part of the job is essentially getting to know a person and building that therapeutic relationship with them" (*CN – female)*

Participants believed that engaging with patients through the TR was the way in which

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

compassion could be demonstrated. This aspect of the nursing role was understood to be essential to the process of recovery.

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

The TR was identified as the unidirectional sharing of stories, where the mental health nurse was able to listen to, tolerate, and contain distress within that relationship.

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

Some participants suggested that this approach to delivering compassion was different from other kinds of nursing.

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

Talking and spending time with patients was considered vital to the development of the TR. However, it was also recognised emotional labour is increased in mental health nursing, as a result of absorbing patients' stories which were emotionally draining.

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

This instinctive reaction to traumatic stories was identified as a compassionate response.

"The things that you hear are so traumatic, so difficult and so deep…we deal with really really complex needs, so I just think that, by being invited in someone's' life to share those things, you automatically open yourself to being a compassionate person" (CN – female)

Generally, the role of the mental health nurse was to actively respond to and help alleviate distress. However, nurses were aware that some patients can mask distress, which confounded compassion (as a response to suffering) because suffering was not explicit.

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

The above quotes illustrate how Mental Health nurses view themselves as competent in recognising and responding to psychological distress, distinctive from the recognition of physical pain.

Theme 3: Barriers to compassion

All participants spoke about the daily tasks and responsibilities involved in the role of a mental health nurse. According to one participant, compassionate care relied very much on the nurse devoting their own time to spend with patients. This was because they had not been able to complete administrative duties during working hours.

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

Another participant indicated that, despite a desire to 'express' compassion, they often had to make a conscious choice to focus on tasks and risk assessments. This was necessary in terms of accountability of the individual nurse.

"Someone might say 'I'm going to kill myself today'…they might say that and then it becomes, I've kind of got two simultaneous responses to that so one is 'oh my God, you're a person in front of me who is saying that they are going to kill themselves, what is happening for you that must be so awful to even have those thoughts'…. the other side of that is 'okay

someone's just told me that they're going to kill themselves so I need to ask this question this question and this question so I can document it in the risk assessment'" (CN - male)

While participants were aware of the underlying expectation for compassion, the need to assess risk was considered to divert time away from therapeutic engagement, and thereby from the delivery of compassionate care.

3.1 Ethical constraints on compassion

The need to continually assess risks was part of what made the role of mental health nurse a particularly challenging one. The assessment of risk and nurses' involvement in restrictive practices caused ethical dilemmas as it conflicted with their perceptions of compassion.

"I think that I think that there is a tension between coercion, coercive practice and that the culture and the accepted way of doing things which often, especially in hospitals, it is paternalistic and controlling, and for me, it just makes me feel very sad and it makes me feel very angry" (CN – male)

*"I hate restraining people, I hate **forcibly medicating people** – [emphasis] even if I know that they definitely need it and there is no other recourse and that actually, the act [Mental Health Act] is being applied correctly, I still, I still don't want to be a part of it, so, and then yeah, there have been times when I, you know. You're the nurse in charge, they're under a section[3], and you have to erm, you have to er, you know, you have to implement these measures, you know do a section 5(2)[4] or whatever and then there's like a level of emotion there, and hostility like an animal emotion where you're having to contain someone who is you know risky and that impacts on someone's ability to be reflective and compassionate" (CN – female)*

In mental health, rather than alleviating suffering, distress was felt to be purposefully caused by implementing restrictive practices. This was understood to make mental health nurses' practice much more complex in terms of responding with compassion.

"It's almost like we're creating a need for it [compassion] because we can be the cause of some people's distress, or further distress, and we need to be compassionate…. if someone is upset because they want to leave hospital and want to go on leave, but can't, or, it can be very hard…I can't

[3] Being 'sectioned' means that a person is detained in hospital under the Mental Health Act (2007). There are different types of sections, with different rules regarding how long a person can be detained in hospital (*see* Mind.org.uk for easy-read summaries).
[4] A section 5(2) is a temporary holding power of up to 72 hours, in which time a person must be assessed by two doctors who will decide whether someone needs to be kept in hospital for longer.

if the leave[5] isn't there, I can't just say 'okay go on leave' because I know that would alleviate the distress. I have to try and find other ways to do that and sometimes it's just impossible and simply they just want leave and if you can't give them leave then – it's hard to alleviate that distress erm, yeah, so [pause] some of our restrictive practices and stuff can cause distress and I [pause] that's where compassion is a bit [pause], a bit tricky" (SN, ward-based – female)

Another participant questioned the history of psychiatry and the ingrained institutional practices [and the influence of this on contemporary mental health nursing] in relation to their own values. In the quote below they reflect on their personal ethics, and ethical discussions with fellow students while training to become a mental health nurse.

"I think it made me question the institutional elements of caring for a person and the culture of erm, I would say psychiatry really but also mental health nursing. Erm and how, the question of what is truly caring for a person? what is truly compassionate practice and can you, for example, deprive someone of their liberty and restrain them and claim that you're acting in their best interests and that you are acting compassionately? I think probably for some people yes you can, but I think for me personally, I think, no" (CN – male)

3.2 Administrative burden: A barrier to compassion

Reflecting on prior experiences of having worked in in-patient areas, participants conveyed a sense of disillusionment with the nursing role because of the high level of administrative duties involved in the role generally. These duties mismatched their expectations of nursing prior to completing their nurse training/education.

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

[5] When a person is detained in hospital under the Mental Health Act (2007) they may leave hospital for short periods of time. This is known as Section 17 leave, which must be authorised by the patient's psychiatric doctor. A person's leave will often have conditions, such as what time the person must return to the ward.

High 'task-based' activities made it difficult to manage time effectively, allowing too little time to think about the clinical aspects of the job – including compassion. This caused frustration and feelings that staff could not realistically deliver the service that patients might expect. This led to concerns about patients' experiences of care.

> "*In in-patients, things are going off right and centre and you've not got that capacity to reflect…its' frustrating because you don't feel like you're providing a service that you're supposed to….That's surely got to have an effect on what they [patients'] think, like nobody's listening to me" (SN, ward-based - male)*

Insufficient staffing and high-administrative burden were reported to significantly limit staffs' ability to demonstrate compassion within the role - as they would wish to.

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

It was clear during the interviews that low staffing, and high levels of paperwork led to increased pressures on staff. These working conditions contributed to fatigue and exhaustion.

> *"Working in this job there's many factors to it and it's not a simple as being able to support someone…..it's trying to* ***maintain people*** *[emphasis], like, well from* ***burning out*** *[emphasis] really and that's not compassionate er, like fatigue just, it is, it is really difficult" (SN, ward-based - male)*

Participants were passionate about needing to have time to attend to patients, and not losing out on *"opportune moments" (SN, ward-based, male)* to explore patients' experiences and issues. Support for patients in distress could be easily overlooked as a result of pressures on existing staff.

> *"I think all the external pressures sometimes, you know, they de-sensitise people, I think erm [pause] then they forget, they forget, sometimes you forget that not like somebody's that they're unwell. Like I said, it's sort of miss-interpret things and you miss out the whole cues for how someone's feeling and then, sometimes you make*

the wrong decision then about how you support somebody" (SN, ward-based - male)

Support staff were perceived to have much more to spend with patients, and therefore more time for compassion.

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

Theme 4: Perspectives on compassion policy

When prompted to think about healthcare reforms and the introduction of a compassion 'policy', most participants rejected the policy discourse on compassion.

"I don't need a policy to tell me to be compassionate…. I mean yes there is a compassion policy, but good God unless that's intrinsic we are losing something here. The idea that you have even got to have a policy on it for me it's [laugh]. I mean how do you measure it, how do you even operationalise it, what is tangible….I have a reaction to the word compassion at the moment because….it's hear there and everywhere, I think it's become a bit of lip service because sometimes how services treat our workforce isn't in a compassionate way" (*SNP – female)*

As identified by participants, compassion was viewed as inherent and therefore could not be enforced via policy.

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

Compassion was perceived in terms of the essence of nursing practice.

"Do I think about compassion because of the trust values? ***No*** *[emphasis], I think about them because erm, it's part of nursing and part of what I do essentially" (CN – female)*

When discussing the next cohort of aspiring nurses and interviewing people to join nursing, however, compassion was expected to be appropriate to join nursing.

> *"We only allow people to obtain jobs in the trust if they can display values erm, and that's how we interview as a trust, so I guess it does underpin pretty much everything. All the questions are based on a person's values and hopefully that is a good measure, good measure of whether they are displaying the right amount of compassion for what we are looking for as a trust in a role. It would be the person who displayed the most compassion would get a role in nursing" (CN – female)*

In terms of developing compassion in the future workforce, policy was rejected. However, a focus on the fundamentals of care was viewed as cultivating compassion.

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

The above quote implies a culture where student nurses are regarded to be obliged to spend time doing, what is perceived as the 'real' work before they could be considered ready, or able to, progress in their career.

DISCUSSION

Mental health nurses identify compassion as an innate human characteristic. This aligns with previous research which suggests nurses embody compassion (Durkin *et al.,* 2019). Compassion was reported as being fundamental to *why* individuals chose to enter mental health nursing and understood to be core to their practice and demonstratable through engaging with patients via the therapeutic relationship. However, participants reported having little quality time with patients, which conflicted with their ideals for delivering compassion. Studies have shown that a disillusionment with the realities of nursing - conflicting demands on nurses' time to spend with patients and being required to be increasingly productive with fewer resources – is one of the reasons nurses choose to leave the profession (Nolte *et al.,* 2017). The administrative burden was felt to be a barrier to delivering compassionate care, which echoes the work of West *et al,* (2021)

who have noted the stress caused by excessive workloads. These factors are important considering the increased global prevalence of mental health difficulties (Mari & Oquendo, 2020).

In the current study, participants perceived compassion to positively contribute to the recovery process. This supports the work of authors who claim compassion can improve health outcomes (Gilbert, 2010; Hammarström *et al.,* 2020). However, organisational structure was a constraining factor for compassion. This has been previously cited as significantly limiting compassion (Crawford *et al.,* 2014). Participants' desire to engage in the therapeutic relationship was reported to be impeded by high pressured working environments; low staffing levels; risk assessments. Moreover, study participants deemed restrictive practices to conflict with their underlying ethical framework. Involvement in restrictive practices conflicted with compassion, as defined by study participants. The emotions invoked by the implementation of restrictive practices has been shown to cause high levels of work-related stress for mental health nurses (Power *et al.,* 2020). However, restrictive practices and risk assessments were considered necessary to ensure staff accountability and patient safety. Consequently, mental health nursing was particularly challenging in terms of demonstrating compassion. In this sense, policy on compassion is unrealistic and untenable, as previously argued by Tierney *et al* (2018).

Participants in this study strongly rejected any influence of compassion policy on their intentions to express compassion. Regardless, there were high expectations for nurses to demonstrate 'a good measure of/the right amount of' compassion. Furthermore, participant's discourse implied a culture where compassion is an expected standard, echoing government discourse in which compassion is presented as a universal indicator of 'high quality' care. This supports theoretical assertions about the power of discourse to induce attitudes (Van Langenhove & Harré, 1999; Willig, 2008) and may impact on new nurses who are entering nursing with established ways of thinking, which may be more [or less] conducive to perceived compassionate nursing behaviors. Hence, awareness must be raised, within the profession, regarding structures known to limit compassion (Crawford *et al.,* 2014), which individuals may not immediately recognise as influential in their professional conduct.

However, by discursively positioning themselves (Willig, 2008) as the 'source' of compassion (i.e., part of the personal and the profession), mental health nurses are able to attribute certain

characteristics (i.e. compassion) to their role, strengthening their collective sense of professional identity. Historically, nurses have struggled to establish their professional identities (Morrall, 1998), having been shaped by the well-documented argument about medical dominance and discourses of nurses playing a *'handmaiden role'* to physicians (Buchanan-Barker & Barker, 2005, p. 541; Chaney, 2020). Discourses that claim compassion can improve health outcomes essentially transform this nurse-physician dynamic, particularly as mental health nurses consider themselves to employ the therapeutic use of (compassionate) self to aid the recovery process for patients. In effect, becoming the ones delivering care as well as 'treatment'.

Previous responses to compassion policy, for example Cummings & Bennett (2012), have perpetuated a narrative of individual responsibility for compassion. Participants' discursive accounts reflected feelings of responsibility for compassion. By taking up this discourse, and by implication, an 'irresponsible' healthcare professional would be considered one who does not enact compassion. This places increased pressure and feelings of guilt on an already stressed workforce (West *et al,* 2021). This is precisely what neoliberal discourse seeks to achieve (Springer, 2016), ensuring compliance through governance of 'the soul' (Rose, 1999). For Willig (2008), certain practices become legitimate forms of behaviour from within a particular discourse, thus, participants discursive constructions of themselves as 'the essence' of compassion reinforces the idea that frontline workers are responsible for enacting compassion. As Crawford et al (2014) have asserted, it is our contention also that compassion can only be achieved by providing services that are designed *'in and by government and healthcare organisations*' (P. 3594).

Strengths & limitations of the study

Findings are limited by the unstable nature of discourse and subjectivity in the social world. Subjectivity is constantly being reconstituted each time we engage with discourse. Therefore, data are representative only of the social reality of participants at the time of collection. Just one location was studied; future research would benefit from analysing a larger corpus of language, from a wider geographic area. The small number of participants limits our findings. Moreover, the sample was mostly female, which privileges women's voices over men. The cultural diversity of the sample is unknown, which reduces the transferability and generalisability of our findings.

However, we do not claim to make generalisations beyond the point of participants' discourse presented. Our intention here was to extend the debate on compassion to the mental health practice setting, providing a platform for future research.

CONCLUSION

Mental health nursing is complex and involves clinicians making difficult decisions to both improve patients' experiences of care and maintain safety. This paper has demonstrated how mental health nurses view compassion as core their clinical practice yet, in 'reality' compassion is problematic due the practical and emotional constraints upon nurses' everyday practice. This study also highlights how the introduction of government policy can be challenged by clinicians, in this case mental health nurses, who are working to defend their position as 'compassionate' practitioners from within their profession. Participants demonstrated high expectations for the intra-professional practice of compassion. This has implications for those entering the profession - to attain the standards required, despite the anticipated complexities of enacting compassion and structural barriers to delivering compassionate care. We recommend, therefore, that the growth of neoliberalism and the influence of this on nurses generally is an area for further research and specifically looking at the ways in which it plays out in provision (or not) of compassionate care.

RELEVANCE FOR CLINICAL PRACTICE

System-wide action must be taken to increase and support the mental health nursing workforce to strengthen the practice of compassion. A sustained investment is needed to protect time for nurses and to improve the resources and processes to ensure nurses can provide compassion. This will be fundamental to improving health outcomes that are asserted to be enhanced through care that is underpinned by compassion.

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