The Nuance of Compassion: An exploration using reflexive thematic analysis of how NHS staff working in Older Person's Mental Health talk about their experience and understanding of compassion

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Abstract

According to NHS Wales, compassion is one of health care's core values (Wales.nhs.uk, 2020) and can be defined as the emotional response to another's pain or suffering involving an authentic desire to help (Goetz et al., 2010). Caring for the health and well-being of others is intrinsically compassionate behaviour (West, 2017); however, at times, the NHS appears to be marked by a lack of compassion. The Staffordshire inquiry, which saw a substantial rise in patient death rates, highlighted how a lack of compassionate care could lead to patient suffering and concluded that there was a need for more patient-centred and compassionate care (Francis, 2010). The Parliamentary Review of Health and Social Care in Wales (H&SC) (2018) highlighted the need for change in health and social care provision, claiming the need to bring health and social services together with a focus on the needs of individuals and a greater emphasis on well-being (HEIW, 2020). 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' is a long-term workforce strategy that sets out the vision, ambition, and approaches that put well-being at the heart of the plans for both H&SC Wales. 'Together for Mental Health' is a strategy that seeks to implement these improvements alongside 'A Healthier Wales workforce strategy' within mental health services across Wales (Cymru.gov.uk, 2020). Health and Education and Improvement Wales (HEIW) claim that this workforce strategy is the opportunity to develop a compassionate culture that creates leaders who demonstrate collective and compassionate leadership. This initiative is based on the idea that creating compassionate leaders within healthcare can and will result in a compassionate culture (West, 2017). With older people's mental health wards within the NHS catering to both older adults who are living with a dementia diagnosis and/or currently experiencing distressing mental health symptoms, they are often challenging places to work, with there often being high levels of risk and aggression (Berkowitz, 1993). This can be specifically the case for nurses and healthcare support workers who are more likely to be assaulted while working in inpatient wards for older people living with a dementia diagnosis than those working in other inpatient settings (RCP, 2008). This research thesis was designed to gain a greater understanding of mental health nurses and healthcare support workers' experience of working in an older person's mental health inpatient ward in Wales. This study explored nurses' experience and awareness of their personal, professional, and organisational compassion and their views on how this may affect patient care and job satisfaction. Interviews with fourteen nurses and healthcare support workers who work on OPMH inpatient services within SBUHB were completed, and data was analysed via reflexive thematic analysis. Analysis of the data relating to participants' descriptions of compassion resulted in developing of three overarching themes. The first theme, Compassion is Relational, includes how compassion influences and shapes relationships with

patients, colleagues, managers, and people in general. Within this theme, three subthemes were created: i) "We are just numbers, they do not care, ii) Togetherness: "Everybody helps each other out," and iii) Genuine desire to care. The second theme, Compassion is Contextual, highlights how compassion can vary between cultural, social, and individual factors but can also be affected by environmental and situational factors such as workplace ambience and the nature of the diagnosis. Within this theme, three subthemes were created: i) compassion or efficiency, ii) the toll of caring: compassion fatigue in dementia and mental health, and iii) existential Angst. The final theme, Compassion is Personal, includes a person's experiences, beliefs, and values and how these can shape and determine their ability to form self-compassion. Within this theme, three subthemes were created: i) Wounded healing, ii) The compassionate self: Mindfulness, empathy, and self-reflection, and iii) "It's just who I am, it's innate. This study has provided insights into aspects of compassion that may often be overlooked. That compassion does not always have to be a 'grand gesture' where you solve complex issues or cure or aid suffering for others. While it can be these things, it is also being open and non-judgemental, taking time to turn up for and be present for, and engaging in the more minor, everyday acts of relational support. It has also highlighted the importance of self-compassion and how self-awareness and reflection in a noncritical way can also aid your compassion for others.

Introduction

In the vulnerability of illness, patients are not just cases; they are individuals seeking medical expertise and the reassuring embrace of human care—a poignant reminder that within the clinical realm, compassion remains the most vital prescription.

At the heartbeat of healthcare, the National Health Service (NHS) draws its vitality from medical expertise and cutting-edge technology and an often-overlooked force that defines its very essence: compassion. Stripped of compassion, the NHS becomes a mechanised entity of procedures and prescriptions, lacking the human touch that elevates it beyond a mere institution to a vital lifeline for millions. Caring for the health and well-being of others is intrinsically compassionate behaviour (West, 2017), with compassion being one of the core values of health care within Wales (wales.nhs.uk, 2020).

Yet, some have noted, experienced and claim there to be a compassion crisis within the NHS[1] (Trezeciak and Mazzarelli, 2023[2]) but also society more broadly, with some claiming that the moral compass of society has lost its coordinates of compassion, civic good, and universal comfort and protection. With self-interest, consumerism and individual responsibility promoted in their place (Cromby, 2022). An inquiry into the care provided by the Mid Staffordshire NHS Trust between 2005 and 2009 has highlighted the impact poor care quality can have on its patients. The Staffordshire inquiry, which witnessed a significant increase in patient death rates, shed light on how the absence of compassionate care can result in patient suffering. It concluded that there was a requirement for care that is more patient-centred and compassionate (Francis, 2010). From this, the campaign *Cure the NHS* (2013) was formed by relatives of patients who were treated at Mid-Staffordshire NHS in a bid to improve the care that was being delivered across the NHS. The Francis Report (2013) examined the causes of the failings in care at the hospital and made 290 recommendations, of which, an increase and need for compassion within healthcare and leadership within the NHS were stated. This inquiry

[1] The case for compassion (bma.org.uk)
[2] Compassionomics | Evidence That Caring Makes a Difference

proposed how a lack of compassion can result in significantly poor quality of care and the detrimental effects this can have on patients.

Many claim that compassion in healthcare offers numerous benefits for staff, patients, and the organisation. For example, receiving compassion can lead people to experience positive emotions such as gratitude, pride and inspiration (Lilius et al., 2008). When healthcare staff treat patients with compassion, patients are more satisfied, which, in turn has an impact on staff well-being (Clyne, 2018). Patients describe feeling compassion when they feel known by nurses and when nurses spend time with them despite the appearance that they do not have the time to give (Dewar and Nolan, 2013). Moreover, research indicates that caregivers are more likely to establish a connection with their patients (Kahn, 1998) and deliver holistic care that addresses the entire person rather than merely the illness (Brody, 1992; Cassell, 2002) when they exhibit compassion.

Previous complaints and investigations highlight the potentially detrimental effects of healthcare services lacking compassion on patient care. Conversely, research indicates the positive influence that compassion can wield on an organisation and the individuals—staff and patients—associated with it. The mentioned studies and initiatives emphasise the significance of staff within healthcare services receiving and experiencing compassion from their colleagues and the organisation itself.

This study explores compassion further, specifically compassion within the NHS. This study hopes to gain an understanding of how staff working within the NHS understand, make sense of and experience compassion within their workplace.

What is compassion?

With a lack of consensus on the definition of compassion (Strauss et al., 2016), how compassion is interpreted and understood will vary between individuals based on their subjective experiences. This introductory chapter aims to delve into the diverse theories and perspectives on compassion across various disciplines and cultures to gain a comprehensive understanding of this complex concept. Due to their similarities with Psychology, with their emphasis on the exploration and understanding of language, human behaviour, and social interaction, I initially scoped the literature on compassion

within the social sciences, focusing on sociology, theology and philosophy. However, subjects such as politics and economics also demonstrated recent links to compassion. For example, the global compassion coalition (founded in 2016) aims to build a world based on compassion. They discuss the role compassion can play in economics, arguing that economies, as systems created by society, no longer prioritise the good of humanity and only serve the welfare of a minority. It is suggested that a compassionate economy can free people to live a life that is good, happy, full and equitable (Hawkins and Nadel, 2021). Similarly, 'The *Wellbeing Economy Alliance'* (founded in 2018), the leading collaboration of organisations alliances, movements and individuals working towards a Wellbeing Economy, highlights how in a well-being economy, solutions are person-centred, geared towards environmental protection and regeneration, and long-term[3]. Within the political realm, *Compassion in Politics*, as an organisation, claims that compassion has been edged out of the political debate and replaced by a politics of fear, anger, and division and a narrative which emphasises individual success over collective well-being and happiness. Their campaigns include; *Stop the nastiness in politics: MPS need a new code of conduct* and a bid to "*make all new laws pass a compassion threshold"*[4]*.* Whilst compassion might be underrepresented within typical political and economic studies and writings, these initiatives and organisations are an example of how compassion is being 'brought to life' within these subjects and in the current world.

Theology, Philosophy and Sociology

Compassion is also a subject that is at the core of the main religious texts. While comparatively little has been written from a theological perspective regarding the study of compassion, nevertheless compassion is a concept that is present throughout most religious writings; thus, compassion is spoken of throughout the Old and New Testaments, where God's compassion is emphasised towards the marginalised, the sick, and when forgiving sinners (Rashedi, Plante and Callister, 2015). In the Quran, there are frequent mentions of Rahma (compassion), encouraging Muslims to show compassion to each other and to seek Allah's compassion and forgiveness (Alharbi and Hadid, 2019).

[3] Wellbeing Economy Alliance (weall.org)
[4] Compassion in Politics

Within Buddhism, Karuna (compassion) is a core element in Buddhist theology. It reflects the Buddha's deep concern for the suffering of all beings and his teachings on alleviating suffering through compassion and loving-kindness. Many view compassion as a pathway to enlightenment and a means to break the cycle of suffering (Davidson and Harrington, 2002). The theology of compassion is often spoken of in relation to caring for others, alleviating suffering and serving the way for moral and spiritual growth.

Similarly, compassion plays a central role in many philosophical perspectives, with some philosophers, for instance, deriving compassion from theories of virtue and justice (Van der Cingle, 2014). Philosophers such as Schopenhauer, Rousseau and Seneca all wrote that compassion is a fuel for social justice wherein the highest good is human well-being (Williams, 2008). Within the Sociology literature, compassion is a concept associated with morality, and to be affected and moved to action by another's distress is a basis for living a moral life and creates a framework for social order (Armstrong, 2010; Doris, 2010). While compassion is a prevalent concept discussed across various disciplines for quite some time, there is a noticeable absence of comprehensive definitions within these fields. However, a common thread among them is the notion that compassion entails an initial awareness and concern for another person's distress, followed by a desire to alleviate that suffering and provide assistance.

Compassion cross-culturally.

As previously mentioned, the concept of compassion has been a subject of extensive literature, with numerous studies claiming its positive impacts. Despite this wealth of research, a notable gap exists in the exploration of cross-cultural variations in compassion and the diverse factors that influence it, as highlighted by Montero-Marin et al., (2018).

Cross-cultural studies often predominantly involve Western demographics. For example, when researchers studied Buddhist practitioners, who one might anticipate having a strong sense of compassion due to Buddhism's origins, one study found that students in the USA who practised Buddhist meditation showed higher levels of self-compassion in comparison to college undergraduates and older adults recruited from the broader community (Neff and Prommier, 2013). However, when exploring compassion in Eastern, and more collectivist cultures (where Buddhism is widely followed) such as Japan, Taiwan

and Sri Lanka, lower levels of compassion were found and higher levels of self-criticism were reported when compared to USA participants (Kitayama and Markus, 2000). It is proposed that the collectivist social dynamic in Eastern cultures inhibits people from receiving compassion from themselves and others due to Eastern cultural norms discouraging help-seeking behaviour, as seeking help is considered a failure that brings shame to one and those around oneself (Kariyawasam et al., 2022; Kee, 2004).

Similarly, various cultures have unique ways of expressing and manifesting compassion. For instance, in Iran, in 2015, a single individual initiated a heart-warming practice during the cold winter months in the city of Taarof. They introduced the concept of "*walls of kindness*," where the message "*if you don't need it, leave it; if you need it, take it*" was prominently displayed[5]. This compassionate act aimed to prevent and reduce the suffering of the homeless during the harsh winter, and it has since evolved into a tradition in several cities across Iran. During the transition of apartheid in South Africa, the concept of *Ubuntu* became prominent. Nelson Mandela described Ubuntu as "The profound sense that we are human only through the humanity of others; that if we are to accomplish anything in this world, it will in equal measure be due to the work and achievements of others." (Page xi, 2008, *Mandela's Way: Lessons for an Uncertain Age*). Ubuntu was a primary concept within the Truth and Reconciliation Commission, which recognised the importance of forgiveness, reconciliation and peaceful coexistence (Ntlapo, 2022). In Western cultures, people commonly engage in charitable acts, volunteering, and community support, often classifying them as humanitarian actions. Researchers have pinpointed three value orientations within these activities, and one of these orientations is the intent to alleviate suffering wherever it is encountered (Calhoun, 2008).

The examples I have discussed above highlight the complex nature of compassion, emphasising its personal, cultural, contextual, and relational dimensions. Collectivist cultures tend to emphasise group well-being over individual concerns, while other cultures prioritise individuals, personal connections, and personal well-being. However, all the instances mentioned consistently recognise compassion as actions aimed at alleviating the suffering of others.

[5] https://www.theguardian.com/world/2016/jan/14/irans-walls-of-kindness-offer-help-to-the-homeless

The concept of self-compassion is often included within research, texts, and literature around compassion. Self-compassion has been defined as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering, and to heal oneself with kindness" (Neff, 2003b, p.87). Further, it has been found that there are three interrelated elements to self-compassion: self-kindness versus self-judgment, a sense of common humanity versus isolation, and mindfulness versus over-identification. Self-kindness means being gentle and understanding with yourself during times of suffering. It involves forgiving yourself, empathising with your feelings, being kind and patient, and accepting that it is okay to make mistakes because everyone does. Feeling connected to others and recognising that everyone faces challenges and makes errors is part of having a sense of shared humanity. Being mindful means being aware of your feelings without ignoring them or getting too caught up in them. It lets you acknowledge your flaws without getting overwhelmed by self-criticism. These three aspects of self-compassion work together to help face difficult situations with kindness towards oneself rather than being critical (Neff, 2003a; Leary et al., 2007). It has been suggested that self-compassion can harness a person's ability to offer compassion to others (Hargreaves, 2021). Like compassion, however, how self-compassion is understood and interpreted can differ amongst various cultures, disciplines and contexts.

Synonyms of Compassion.

Throughout literature and when researching across disciplines, compassion was often included with other concepts and would sometimes be used interchangeably with these other concepts. Compassion originates from the Latin word *Compati*, with *Pati* meaning to suffer and *com* meaning with. This aligns with the above views on compassion throughout different disciplines and how compassion could be viewed differently from its often-used synonyms: kindness and empathy. Mazzarelli and Trzeciak (2019) claim that compassion is different to empathy. Empathy, as they define it, is the "feeling and understanding component (i.e., "detecting and mirroring another's emotions and experiencing their feelings)" (page 29), whereas compassion, they claim, involves taking action. They suggest that empathy is a prerequisite to motivate acts of compassion. Mazzarelli and Trzeciak further claim that functional magnetic resonance imaging (fMRI)

supports this claim with research claiming to demonstrate a difference in the areas of the brain that 'light up' when participants were prompted with either empathy or compassionate information. Within their book, *Compassionomics*, Mazzerlli and Trzeciak highlight what they term a 'Compassion Crisis' by which they stress how compassion is decreasing across countries, and within disciplines. They stress the need to reinstate compassion into health and social care, and the world more generally. They further claim that compassion is "*not simply being kind*" (page 30), as a key aspect of compassion, they believe that it is a response to another's pain or suffering, whereas kindness, they claim does not require the presence of human suffering. However, some disagree with this difference and claim that a compassionate act can exist without suffering, as compassion drives us to improve people's circumstances generally, to reduce the likelihood of any suffering occurring and to increase opportunities for people to thrive (Hargreaves, 2021). Hargreaves, instead views kindness, and other similar concepts such as courage, respect, humility, empathy, and patience as reinforcers, supports and enablers of compassion.

In summary, the concept of compassion has been a pervasive and enduring theme across diverse cultures and disciplines. While the manifestations of compassion may vary across societies and countries, a broad consensus exists that it entails the acknowledgment of suffering and a sincere desire to undertake actions to alleviate that suffering. Despite this shared understanding, ambiguity persists regarding the precise nature of compassion, the factors influencing individual differences in compassion, and the catalysts or facilitators that enhance our capacity for compassion.

This raises fundamental questions about the essence of compassion, the determinants of varying levels of compassion among individuals, and the factors that contribute to or hinder our ability to embody compassion. The subsequent section of this chapter will delve into different psychological theories of compassion, aiming to provide deeper insights into these questions and illuminate the complex dynamics that underlie the expression and cultivation of compassion.

Psychological Theories of Compassion

There are psychological theories that have explicitly attempted to explain what it means to be compassionate, of which, two theories are discussed below. Further to this,

compassion, as a concept can be explored and understood further through psychological theories that have developed in an attempt to understand relational and intrapersonal aspects of human beings, some examples of prominent theories within the counselling psychology field are discussed below. These theories may provide insight into what factors may harness or inhibit compassion within staff members, and give insight into how to create the best environment for staff within organisations and healthcare to allow for compassionate care to be delivered.

Kanov et al. (2004) identified three sub-processes that collectively define compassion: noticing, feeling and responding. *Noticing* another person's suffering was determined to be a critical first step – becoming aware of the suffering of another. However, noticing on its own was not seen to be enough – additionally, *feeling* requires that you must suffer with the other person or empathise with their hurt. Finally, *responding* compassionately involves taking actions to ease the person's suffering. Atkins and Parker (2012) acknowledged Kanov et al.'s sub-processes but proposed that a fourth component, understanding was also necessary, along with the re-labelling of the term "responding". They believed that all of these steps are compassionately responding and so it is more appropriate to term the final step as acting or helping. Thus, Atkins and Parker state the four components of compassion are, attending – we must pay attention and notice another person's suffering, as described by Kline (1999), it requires that we 'listen with fascination'. Secondly, understanding – this is dependent on listening deeply and is where a person makes an appraisal of the cause of suffering and truly attempts to understand the person's suffering. The third component is empathising – this is feeling the strains, pains, anxieties and frustrations of those suffering; and finally, the fifth, is helping - taking intelligent (thoughtful and appropriate) action to help relieve the other's suffering.

Gilbert's (2017) caregiving social mentality theory offers one explanation as to how compassion can be understood as a form of intrapersonal relating in which the interpersonal mentalities of care-seeking and caregiving are activated. Gilbert has distinguished between instrumental caring (practical and task-focused) and emotional caring and states that when a person is in the care-giving social mentality, it links their attention (e.g., to the needs of others), ways of thinking (e.g., how to be helpful), feelings (e.g., of concern, empathy, kindness) and behaviour (attempting to alleviate suffering).

Gilbert highlights the importance of this caregiving social mentality in harnessing compassion (and self-compassion) as it shapes our feelings thoughts and behaviours in a particular way that is different from other social mentalities (Gilbert, 2010). He further explains how other emotions such as stress, fatigue and anger can hinder one's ability to deliver compassionate care. He argues that human emotions are organised through three basic systems: threat and self-protection, incentive and resource seeking, and, soothing and contentment. Gilbert explains how when the incentive/resource-seeking system fails, it can result in beliefs that chances of success have disappeared which can cause feelings of burnout, exhaustion, defeat and depression where the person may give up altogether (Gilbert, 2010). Thus, Gilbert highlighted the link between compassion and caregiving based on human emotions and needs. Studies have highlighted the importance of this link, emphasising that patient satisfaction is higher in healthcare organisations and teams where staff's health and well-being are better (West and Markiewicz, 2016).

Compassion emerges as a fundamental concept deeply ingrained in various counselling psychology and psychotherapy theories, reflecting its pivotal role in fostering psychological well-being. Below are some examples of where compassion can arise differently based on different psychological theories. For instance, the humanistic psychology of Rogers et al. (1961) highlights the imperative of unconditional positive regard. Rogers advocates for maintaining not only unconditional positive regard but also empathy and congruence as essential components in alleviating human suffering. Unconditional positive regard involves accepting and valuing a person without judgment. In the context of compassion, this aspect aligns with recognising the inherent worth and dignity of individuals, irrespective of their circumstances or actions. Empathy, as discussed above, has been considered a pre-requisite for compassion (Trzeciak, Mazzerlli and Booker 2019). Empathy in person-centred therapy is akin to the empathetic understanding that compassion entails, fostering a deep connection and emotional resonance with the suffering or challenges faced by individuals. Lastly, congruence involves the therapist being genuine and transparent in their interactions. In the context of compassion, genuineness is crucial for building trust and authenticity in relationships. Compassion requires sincere and authentic responses to the emotions and needs of others. A genuine and transparent approach, as advocated by congruence, contributes to

creating a safe and supportive environment for individuals to express their vulnerabilities and receive compassionate understanding (Jones et al., 2016). As such, Carl Rogers's three key aspects of person-centred therapy directly align with the core principles of compassion discussed by Kanov et al., (2004) above. Together, they form a framework that emphasises understanding, acceptance, and genuine connection, fostering an environment conducive to the expression and reception of compassion in therapeutic settings and beyond (Lees et al., 2014).

Similarly, in Klein's object relations theory (1999), the 'capacity for concern' refers to an individual's ability to care about and be emotionally invested in the well-being of others (Summers, 2014). It involves the capacity to extend one's emotional experiences and concerns beyond oneself to encompass significant others in one's life (Froggett, 2002). As noted previously, compassion similarly, involves a genuine concern for the suffering or challenges faced by others. It includes the ability to connect emotionally with others, recognising and responding to their experiences with care and understanding. Hence, a capacity for concern aligns with the essence of compassion, emphasising the emotional connection, understanding, and genuine concern for the well-being of others. Further, Kohut (1977) aligns aspects of self-compassion with the self-object theory, emphasising the necessity of interpersonal connections for the development of individual self-experiences. Within this framework, self-compassion emerges as a source of emotional safety, mitigating self-condemnation.

Lastly, Bowlby's attachment theory emphasises the significance of secure attachments formed during early childhood for healthy emotional development. A secure attachment is characterised by a child's sense of safety and comfort derived from a consistent and responsive caregiver (Bowlby, 1979) Individuals who develop secure attachments are more likely to possess a secure emotional foundation. This emotional security contributes to the capacity for compassion, as these individuals have experienced and internalised caring and responsive interactions, forming a basis for understanding and empathising with the needs and emotions of others. Individuals with secure attachment experiences are more likely to bring qualities of compassion, empathy, and support into their interpersonal connections, fostering healthier and more compassionate relationships (Gillath, Shaver and Mikulincer, 2005).

Psychological theories, spanning various perspectives such as those discussed within this chapter, collectively offer valuable insights into the understanding of compassion. These theories illuminate the intricate web of factors influencing compassionate behaviour, shedding light on why individuals may act with empathy and kindness or struggle to do so. Kanov et al's theory provides insight into different 'steps' of compassion, whilst Gilbert's care giving mentality theory may provide insight into how we may strengthen different cognitive functions and thinking types to harness a more compassionate approach or develop policies and ward structures that increase these different aspects of cognitions. The emphasis on unconditional positive regard, empathy, and genuineness in person-centred therapy highlights the importance of fostering a supportive and non-judgmental environment. In turn, psychoanalytic theories like Klein's highlight the role of early emotional bonds in shaping an individual's capacity for concern and care. Attachment theory extends this understanding to emphasise the enduring impact of early relationships on compassionate responses throughout life. By drawing from these psychological theories, we gain a nuanced understanding of the psychological underpinnings of compassion, paving the way for informed interventions, empathy-building practices, and a deeper comprehension of what drives individuals to act compassionately or otherwise.

Older Persons Mental Health Services

As I will discuss in the following chapters, this study places its focus on nursing staff and healthcare support workers who work in older person's mental health inpatient services. Older people's mental health wards within the NHS cater for both older adults who are living with a dementia diagnosis, and/or currently experiencing distressing mental health symptoms. Whilst staffing in these settings consists of a multi-disciplinary team including psychologists, physiotherapists, consultant psychiatrists, medical doctors, occupational therapists and pharmacists, it is mental health nurses (MHN) and health care support workers (HCSWs) that provide 24-hour, hands-on, front-line constant care for patients who are admitted onto the wards. These mental health settings can often be challenging places to work, with there often being high levels of risk and aggression (Berkowitz, 1993). This is particularly true for nurses and health care support workers, working in

inpatient wards for elderly individuals diagnosed with dementia, as they face a higher risk of assault compared to their counterparts in other inpatient settings (RCP, 2008).

When recruiting and training students to become nurses, there is a high emphasis on selecting students who appear to have the right competencies and values – one of which is compassion (Swansea University, 2020). Student nurses have to demonstrate that they can be caring and compassionate and it is emphasised that there should be an increased focus on a culture of compassion and caring within the nurse recruitment, training and education sectors (Francis, 2013). The requirement for student nurses to demonstrate their ability to be caring and compassionate highlights the practical and observable nature of these qualities. It implies that compassion is not only an abstract expectation but that it should be evident in the actions and behaviours of nursing students. Further, the call for an "increased focus on a culture of compassion and caring" within nurse recruitment, training, and education signals a commitment to embedding these values into the broader ethos of nursing education. This suggests a recognition that compassion is not only an individual trait but also that it should permeate the entire educational and professional environment. There is, however, little information or evidence on how to support MHNs and HCSWs to be able to maintain a compassionate approach throughout their career in such a stressful environment. There has been an emphasis on the need to recognise that social, situational, and personal factors outside of the work environment, along with the current dynamics and situations within the workplace, can influence a person's ability to maintain and display compassion (Strahan, 2020). Further, it has been demonstrated that empathic and caring nurses can become victims of the continuing stress of meeting the overwhelming needs of patients and their families, resulting in compassion fatigue, which can then affect job satisfaction, emotional and physical health but also the workplace environment by decreasing staff productivity and increasing turnover (Lombardo and Eyre, 2011). Previous studies and initiatives have attempted to create compassionate cultures within the NHS (C*ompassion in Practice*, 2012, *Leading with Compassion Programme, 2015),* however, few studies have taken a qualitative approach in gathering the views, opinions, thoughts and understandings of compassion from these front-line staff.

Overview of the structure of the thesis

This thesis contains five sections. Following this introductory section is a critical literature review of the relevant theoretical and research literature within this topic area. This section will also highlight the rationale for the present study, the research aims and the research questions. The third section will contain the details of my methodological approach, will discuss my epistemological positioning, methodology, and procedure, and outlines my data analysis process including my own experiences, assumptions and beliefs about the research topic to demonstrate my subjective awareness and reflexivity. Next, the results and analysis sections will report the findings of the study and the themes that I developed through the analysis process, whilst also considering the relevant research literature in relation to the data. The final and fifth sections will discuss the research thesis including the implications for practitioners, a study reflection and recommendations for future research and clinical practice.

Critical Literature Review

Introduction

Following the COVID-19 outbreak, compassion has become a significant concept within Western society, with self-help guides and articles promoting that self-care and compassion are "more essential now than ever" (everydayhealth.com, 2021). However, as a concept, compassion has been spoken about long before the COVID-19 pandemic and has been considered a vital core value of the NHS (Wales.nhs.uk, 2020). As noted in the previous chapter, there many occasions where the NHS has been criticised for a want of compassion. As such, initiatives within the NHS, such as *Compassion in Practice* (2012), *Leading with Compassion Programme (2015),* and *Cure the NHS (2013) a*re heavily focused on increasing compassion throughout the NHS and research has placed its focus on creating compassionate leaderships (West, 2021). This review will examine the literature on compassion within the NHS. I have divided the relevant literature into three sections for review.

The first section will explore compassion at an organisational level and will give an overview of the literature on compassion within organisations. I began here because I believe it is crucial to explore literature that evaluates how organisations have discussed and disseminated compassion. Since the focus of this research is the NHS, an organisation in itself, it seemed essential to examine how the broader discussion and research on compassion have taken place across organisations. This section will then explore any historical and contemporary links between compassion and the NHS. The second section will discuss and evaluate studies on compassion within the nursing staff and healthcare support workers who work within NHS services. As there are few studies on compassion within Older Persons Mental Health (OPMH) inpatient services, specifically concerning nursing and healthcare support worker staff, this section will also evaluate the literature on the general cultures, conditions, and workings of these services. Lastly, the final section will explore psychology, specifically counselling psychology, and studies on compassion, OPMH and the NHS. This section will look to explore the relevance of conducting this research within the field of counselling psychology.

Compassion within organisations – compassionate leadership

The surge in research and conceptualisation of compassion, particularly within workplace contexts, aligns with the global movements aimed at fostering compassion across communities and the broader planet.

It's been claimed that all members of organisations experience suffering at some point in their work life and that this suffering is "a significant aspect of organisational life" (Frost 1999, pg. 128). With many studies claiming to highlight the positive link between compassion and wellbeing (Schwartz, 2003; Post,2005; Pressman et al., 2015), workplaces and researchers actively study the relationship between compassion and workplace well-being as they seek to enhance staff well-being and cultivate an emotionally resilient workforce (West, 2021). For instance, the study by Post (2005) highlights the role of compassionate leadership in creating a supportive work environment and Pressman et al's (2015) study further emphasises the positive outcomes of compassion. These positivist studies, however, do not discuss the scalability and adaptability of such leadership styles across diverse industries, nor do they fully explore potential confounding variables or alternative explanations for the observed effects. Whereas, the study by Schwartz (2003) not only demonstrates a positive link between compassion and individual well-being but also highlights the need for nuanced interventions tailored to specific workplace cultures.

Further, research suggests that compassion may not only bring about positive emotion and foster well-being but it might prevent or minimise organisational suffering, suggesting that experiencing compassion at work connects co-workers psychologically and results in a stronger bond between them (Frost et al., 2000). Compassionate leadership at work is more likely to cause staff to report effective communication to their organisation and to talk about it in positive terms (Lillius et al., 2008, 2001). They further state that compassionate leadership and experiencing compassion at work strengthens the relationship between employees, which reduces employee turnover and increases organisational citizenship. Fryer (2013) emphasised Apple tree - a call centre organisation – which claimed to provide a good example of how compassionate leadership can reduce staff turnover. Within call centres, employee turnover can be high due to the nature of the work. Inspired by the Make-A-Wish Foundation, the CEO introduced a new initiative

that allowed employees to express compassion to each other regularly. Because of this initiative, staff turnover in the organisation dropped by more than 60% in six months. These study's findings, however, do not discuss the potential contextual factors that may shape these relationships. How might organisational culture, industry type, or geographic location affect these correlations? Furthermore, studies have claimed to show that compassion at work reduces negative emotions, for instance, anxiety (Lilius et al., 2008), but also how compassion at work promotes positive feelings such as gratitude, pride and inspiration and it allows the sufferer to recover physically and psychologically (Dutton et al., 2014; Lilius et al., 2008).

Research has also placed its focus on supervisors and leaders within companies demonstrating that supervisors who perceive that their organisation values their well-being are more likely to show supportive behaviour towards the people they manage (Shanock and Eisemberger, 2006). It is however appropriate to note that the study by Lilius et al, took place within an American demographic which included 10% of all employees within an Urban Hospital. This study also utilised a positivist approach in which surveys were completed and analysed via quantitative methods, further questioning the validity of the study's findings.

Moving on to compassion within the NHS, as research into organisational compassion develops and studies claim to highlight the benefit of compassion within the workplace, researchers within the healthcare setting have attempted to apply these findings within the NHS. The NHS is a macro-level organisation in which one of its values within the constitution is that *"we ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need*" (Ham et al., The Department of Health, 2015, p. 5). Studies have attempted to evaluate this core value as a way to explore how compassionate the NHS is for the members of staff working within this organisation and what effect this potential compassion, or lack of compassion, has on patient care. These studies have suggested that compassion is 'infectious' with Poorkavoos (2016) claiming that compassion breeds compassion and Goetz et al. (2010) highlighting that those who receive compassion are subsequently better able to direct their support and caregiving to others. Employees in compassionate caregiving organisations experience a reduced likelihood of compassion fatigue and

burnout among caregivers (Figley, 1995). This also provides them with the much-needed emotional resources that they need to care for their clients (Lilius et al., 2011). Likewise, research on climate and culture in health and social care internationally suggests that leadership cultures of command and control are less effective than more engaging and compassionate leadership styles and implies that compassionate and collective leadership approaches are likely to be most effective (Dickinson et al., 2013, West et al., 2014). However, the unique challenges within the NHS demand a deeper exploration of how specific contextual factors influence the effectiveness of different leadership styles. Moreover, acknowledging potential challenges or barriers to implementing compassion within the NHS would contribute to a more balanced discussion. In consistently embodying compassion, healthcare professionals might encounter obstacles. In the face of these challenges, it becomes crucial for them to adopt effective strategies to navigate and address the complexities that may arise. Compassion, as a cornerstone of patient care, plays a pivotal role in fostering empowerment and enablement among patients. Research findings demonstrate the significance of the physician-patient relationship, emphasising that how healthcare professionals communicate can profoundly impact patient outcomes. For instance, a study involving 3,000 patients revealed that when physicians exhibited abrupt behaviour, patients reported feeling less empowered to comprehend, cope with, and manage their illnesses (Mercer et al., 2012).Moreover, the importance of compassion extends beyond mere patient satisfaction; it has a tangible impact on various aspects of healthcare delivery. Studies indicate that compassion is a key determinant, explaining up to 65% of the variance in patient satisfaction (West, 2021). Furthermore, healthcare providers who consistently demonstrate compassion are associated with more than a 50% reduction in patient referrals and readmissions. Additionally, patients under the care of compassionate professionals experience quicker recovery times.

Research discussed here has demonstrated that having compassion within an organisation has a positive effect on the staff, the company and the consumers within that company. The studies mentioned here involved a range of methods including interviews, focus groups, questionnaires, experiments and narrative and as such give a

broad range of views of compassion. Furthermore, studies have highlighted the benefits that having compassion can have on the staff and patients.

Compassion among Nursing and Healthcare support workers

An investigation into the care provided by the Mid Staffordshire NHS Trust from 2005 to 2009 has underscored the profound impact of substandard care on patients. The inquiry in Staffordshire, prompted by a significant surge in avoidable patient deaths, emphasised the correlation between a lack of compassionate care and patient suffering. It concluded that a shift towards more patient-centred and compassionate care was imperative (Francis, 2010). Subsequently, the 'Cure the NHS' campaign (2013) emerged, initiated by relatives of patients treated at Mid Staffordshire NHS, aiming to enhance care standards across the NHS.

The Francis Report (2013) delved into the root causes of care failures at the hospital and proposed 290 recommendations, emphasising the crucial need for increased compassion in healthcare and robust leadership within the NHS. This inquiry illuminated how the absence of compassion could significantly compromise the quality of care, adversely affecting patients. Furthermore, a report by the health service ombudsman, investigating ten complaints across England's NHS trusts, highlighted a stark contrast to the reasonable expectation of dignified, pain-free end-of-life care for older individuals in a hospital setting. Instead, it portrayed a system that consistently falls short in responding to the needs of older patients with care and compassion, failing to meet even the most basic standards of care (Great Britain. Parliamentary and Health Service Ombudsman, 2011).

Compassion is often linked to this frequently cited example of substandard care within the NHS, and it is frequently referenced in current studies on compassionate leadership within healthcare. Research within nursing and health care support workers literature has placed a focus on improving staff training and personal characteristics as a way to improve compassionate care within the NHS. For instance, Arthur et al., (2017) highlighted the role that healthcare support workers (HCSWs) have in providing much of the direct care of older people in hospitals. They aimed to understand the relational care training needs of HCSWs caring for older people through a mix of telephone surveys, focus groups, and semi-structured interviews. They interpreted their findings as

highlighting staff as not viewing relational care as a priority, which was in contrast to the findings from the focus groups with older people which found that their experience of hospital care often hinged on the quality of the relationships they had with staff who cared for them. Furthermore, staff identified a sense of conflict between the need for efficiency and the importance of providing good relational care. Researchers claimed there was strong support for HCSW training in relational aspects, such as kindness, compassion and being friendly and approachable. This study included 70% of NHS trusts across England, telephone surveys of HCSWs, focus groups of older people and carers, semi-structured interviews with HCSWs, and a randomised controlled trial of their intervention that was developed. As such, this study includes a wide variety of staff from across regions, a variety of methodologies and analyses and they conclude that interventions for HCSW training in relational care are characterised by small-scale studies that focus on acceptability rather than efficacy, which they claim their study has not done and as such, further improves the validity for their findings. Similarly, Britain (2015) asserted that recruiting individuals into caring roles must assess not only their qualifications but also their values. In 2014, Health Education England implemented a national values-based recruitment framework published for nursing degree programs. Applicants were required to provide evidence of their commitment and suitability for a career in nursing.

These studies are a few examples that place their focus on the recruitment and training of nurses and healthcare support workers. This approach has been criticised by Osborne (2015) who claimed that testing nursing students for compassion at recruitment is futile, as they suggest that a lack of compassion is a result of difficult working environments and not an individual's values. Similarly, Goodman (2014) suggested that scrutinising the character of an individual nurse could be plausible if only one instance of abuse or neglect occurred. However, in the presence of numerous occurrences of substandard care, a comprehensive analysis from a political and social perspective becomes imperative for holistic comprehension. When contemplating the environment and factors within the NHS that could impact the care provided by nurses and HCSWs, Crawford et al. (2013) proposed that there exists an efficiency discourse operationalised at the point of care. They claim that this discourse emphasises time pressures, care processes, and

organisational tensions in a way that comprises best practices and contributes to the entrenchment of a production-line mentality. Likewise, Flynn and Mercer (2013) revealed that caring and compassion are intrinsic to nursing values. They suggested that any lapses in compassion are more likely attributable to the health policies of the government and the organisational culture of the NHS than to any deficiencies in the conduct of nurses or nursing practices.

When considering compassion within nursing and HCSWs within the NHS, there has been a divide in the different views of where the 'blame' for a lack of compassion originates, within the staff members, as a person, or from wider cultural, systemic and political factors. Few studies have taken a qualitative approach to research staff's understanding and experience of compassion as a way to attempt to create a compassionate care-giving culture.

One study that adopted this approach was conducted by Barron et al., (2017), wherein nine community mental health nurses in Scotland were interviewed to offer insights into their interpretations and perspectives on the concept of compassion. Their research sheds light on the intricate nature of compassion and its influence on emotional responses and relationships with oneself, patients, colleagues, and the employing organisation. Participants identified difficulties in engaging with compassionate practice whilst recognising it as a driving force underpinning the provision of care. Five themes were created; within the 'meaning of compassion' theme participants struggled to articulate what compassion means to them but all stated it was important for the job. 'Stifling compassionate services', organisational demands affected their ability to be compassionate. In the 'Weight of the World' theme, participants identified a link between emotional labour and emotional work and feelings of guilt when forgetting things or making errors and identified a need for time to reflect throughout the day. 'Getting nothing back', participants highlighted that patients with complex, often multiple needs can be a barrier to mental health nurses accessing their compassionate selves. Finally, 'looking after each other', both having awareness of the impact on home life and utilising peer support were highlighted as factors aiding compassionate care. This study highlights nurses' views, understanding and experiences of compassion within a community

specialist service and demonstrates the various difficulties and issues faced which can affect their ability to deliver compassionate care.

Similarly, Petite et al.,'s (2019) study involving student nurses revealed significant barriers to compassionate care in the NHS. Key impediments identified by participants included 'Cultural change in the NHS', 'Workload and meeting targets', 'Lack of time', and the detrimental influence of negative 'Role modelling'. This investigation emphasises the multifaceted challenges faced by student nurses in delivering compassionate care.

In essence, various studies have shed light on the repercussions of a lack of compassion within the NHS, particularly in terms of patient care. Researchers have delved into different facets of compassion, exploring its presence among nursing staff and healthcare support workers. Some studies have focused on assessing the intrapersonal characteristics of staff and their potential improvement through compassion training. Alternatively, other research suggests directing attention towards the recruitment process and proposing methods to assess or measure compassion at the point of recruitment. While there is a spectrum of studies investigating individual factors, a predominant theme emerges – the significance of the NHS's organisational environment and culture. The majority of research emphasises the need to scrutinise the broader context within the NHS, evaluating how the organisational milieu can influence the ability of staff to sustain compassion throughout their professional journey.

Ward Cultures and Environments within Older Person's Inpatient Services

As I could not identify studies of compassion within older person's mental health inpatient services, specifically about nursing and healthcare support workers, this section will aim to provide some insight into the cultures and environments within older persons' care. As the above studies highlight the impact that cultures, contexts and environments can have on staff's ability to deliver compassionate care, it seems appropriate to explore the literature on cultures and ward environments within older person's services.

One factor that is often written within the literature on Older Persons' Mental Health (OPMH) is cultures of blame and bullying. These cultures have been highlighted in healthcare settings with growing evidence that the effects of organisational bullying are not only detrimental to organisational reputations but also are costly in terms of staffing

levels, investigation times and administrative costs (Aquino, 2000; Einarsen and Skogstad, 1996; Raynor, 2000). It is worth noting, however that these studies were completed amongst various populations from America to Norway and included mostly quantitative methodologies. Further, these studies were examining the effects of bullying within organisations in general and as such, their ability to generalise these findings to a UK population and to staff working within the NHS, and within OPMH inpatient services is questionable. Further, these studies did not consider or explore contextual factors that may have contributed to these findings. Lewis (2002b) highlighted the importance of being aware of the continuing criticism and blame culture propagated essentially by central government towards sections of public sector employees (i.e. health care staff, the civil service, etc.); particularly where targets or initiatives are not met.

Similarly, Raynor (2000) suggests that due to its complexity, size and various aspects and cultures, the NHS has a complex organisational profile, and as such, nurses within this organisation are open to such conflicts and are not a homogenous professional group. Davies (1995) sees nurses as continually striving towards liberation from traditional opposition. While this in itself may set up conditions for inter-professional conflict (i.e. between say medicine and nursing), intra-professional conflicts are often focused upon the emergence of conflicting professional subgroups and cliques within nursing. Such groups are often seen as favourable reference groups for nurses to aspire to, which may initiate tensions between less prominent or popular areas of nursing.

The above studies suggest that any potential negative culture within the NHS may result from more macro-level influence as opposed to stemming within the individuals working within those services. Furthermore, studies have suggested that these cultures, which often include the fear of making errors, time pressures (Gilbert, 2013), excessive and often defensive bureaucracy (Cole-King and Gilbert, 2014) and bullying (Cole-King and Gilbert, 2013), are barriers to achieving compassionate cultures.

Moreover, McPherson et al. (2016) stated that compassionate care can be hindered when working in very challenging and pressurised environments. The study aimed to explore the experiences of managing work pressures in front-line NHS staff caring for older adults with dementia. One aspect of the analysis was to explore the factors that facilitate or

hinder self-compassion and mindfulness since these ways of responding to extreme pressure are claimed to facilitate compassion towards others. In their study, ten front-line staff (a mixture of nurses and health care assistants) from three inpatient dementia wards took part in qualitative interviews, which were then, analysed using constructivist grounded theory methods. They concluded that recruiting staff with high levels of compassion and training compassion to existing staff are not likely to significantly improve compassionate care alone in the context of extremely challenging work environments. Rather, organisational changes need to be made to model and reward self-compassion; staff training should focus on self-compassion and mindfulness, without which compassion for others is hindered. Strong professional values, which may instil in care staff a belief in not displaying emotions at work, should be considered carefully by professional bodies to guide from pre-qualification onwards about how to balance professional conduct with the appropriate expression of emotion in response to extreme situations. This study does come with limitations, as highlighted by Connor-Smith and Flachsbart (2007), and acknowledged by the researchers, a number or individual variables may be implicated in work stress including the ages, personality, self-esteem, training background and profession of the participants, which were not explicitly examined within the study. Further, as all participants were recruited from the same NHS trust, the transferability of their findings can be questioned.

A second and rather dominant factor that is often discussed and researched within dementia care is regarding behaviours that challenge. Ample studies have highlighted the prevalence of violence and aggression within inpatient and elderly care services. For instance, Lowe, Wellman, and Taylor (2003) highlighted how violence and aggression in the inpatient psychiatric setting have long been a major cause for concern in the UK and continue to be the subject of a considerable amount of research, official reports, and policy documents. The Royal College of Psychiatrists Centre for Quality Improvement claimed that staff working in inpatient units for elderly people with organic mental illness are more likely to be assaulted than those working in other inpatient settings (2008). With research suggesting that aggression can act as a barrier to the provision of compassionate care (Hunter, McCallum and Howes, 2018; Tan et al., 2015), I explored the

literature on aggression, as a behaviour that challenges within older persons mental health further.

Researchers have placed focus on attempting to explore staff's perspectives of aggression within healthcare. McCann et al., (2014) explored the attitudes of clinical staff toward the causes and management of aggression in acute older age psychiatry inpatient settings. McCann et al. (2014) found that nurses and allied health staff agreed that patients were aggressive because of their environment as opposed to originating from within the individual. This study provides insight that staff working within these environments, who are subject to violence and aggression see external environment factors as being key to affecting the behaviours of those on the wards. The influence of the ward atmosphere on the incidence of aggression is one area that has been acknowledged for some time with Shepherd and Lavender (1999) suggesting that violent incidents are, in fact, more likely to be preceded by external environmental and interpersonal antecedents of this nature than internal, symptom-related ones. This links with research and theories regarding Person-centred care within the context of dementia. Person-centred care stands as a fundamental pillar in the provision of effective dementia care, aligning closely with the principles outlined in the 2018 Alzheimer's Association Dementia Care Practice Recommendations.[6] At its core, person-centred care operates as a holistic philosophy, intricately tailored to the unique needs of each individual, rooted in the establishment of meaningful interpersonal relationships. This approach challenges the conventional medical model, which often prioritises procedural routines, schedules, and organisational requirements over the individual's personal needs (Fazio 2013).

The origin of the term "person-centred care" can be traced back to the influential work of Carl Rogers (1940), who centred his approach on individual subjective experience as the cornerstone for both living and therapeutic efficacy. Tom Kitwood further popularised this term in 1989, aiming to distinguish a more humane care approach from the prevailing medical and behavioural paradigms surrounding dementia. For Kitwood, person-centred care encompassed a comprehensive outlook, emphasising the critical role of communication and relationships in caregiving (Kitwood, 1997). Kitwood's ground-

[6] https://www.alz.org/professionals/professional-providers/dementia_care_practice_recommendations

breaking work proposed an innovative understanding of dementia, framing it as a dynamic interplay between neurological impairment and psychosocial factors, including health, individual psychology, and environmental influences, with a particular emphasis on the social context. Rejecting the conventional medical perspective that rigidly targeted the disease, Kitwood argued that the environment wielded as much influence on the brain as the brain did on an individual's abilities (Kitwood and Brooker 2019). Central to Kitwood's theory was a categorical dismissal of the negative and predictable implications associated with the traditional medical sciences' approach to dementia, challenging caregivers to embrace a more compassionate and personalised methodology (Fazio, Pace, Flinner and Kallmyer 2018).

Kitwood's person-centred care philosophy seamlessly extends and is operationalised by The Newcastle Model, attributed to Ian James (2011), by incorporating personalised assessments, individualised care plans, and collaborative efforts, reflecting a shared commitment to recognising the personhood of individuals with dementia and prioritising their holistic well-being. The Newcastle Model, stands as an innovative approach to addressing challenging behaviours in individuals with dementia, firmly rooted in the principles of person-centred care and compassion (James, 2020). This model commences with a meticulous individualised assessment, considering the unique life history and preferences of the person with dementia. It emphasises the creation of a person-centred care plan that fosters familiarity and security, promoting autonomy and dignity. Collaboration is a key tenet, involving healthcare professionals, caregivers, and the person with dementia, creating a supportive network. The Newcastle Model prioritises training and ongoing support for caregivers, emphasising education on dementia and compassionate strategies for managing behaviours that challenge. (James and Birtles, 2020) This model aligns seamlessly with the philosophy of person-centred care, acknowledging the individuality of each person and fostering a holistic understanding of his or her needs. Compassion is interwoven into the model's fabric, encouraging empathetic responses to behaviours that challenge and aiming to enhance the overall quality of life by addressing the root causes of distress. In essence, the Newcastle Model represents a holistic and compassionate paradigm that integrates person-centred care

principles to improve the well-being and quality of life for individuals with dementia, recognising their unique identities and needs (Patel at al., 2014).

The above section attempts to demonstrate the difficult environments in which nursing and healthcare support workers are working, specifically when working within older person's mental health inpatient settings and the impact that these environments are claimed to have on their ability to maintain and deliver compassionate care to the patients within these services.

Counselling Psychology, compassion and the NHS

This section will explore links between counselling psychology, older person's mental health, compassion and the NHS to evaluate the relevance of this research topic within the field of counselling psychology.

Keum (2018) has highlighted how psychologists have contributed to the academic and political agendas to prepare for older adults' growing mental health needs. In 2016, the *American Psychologist* released a special issue titled, "*Aging in America: Perspectives from Psychological Science*" and included nine articles highlighting the progress and need for continued work on major topics concerning the well-being of older adults regarding retirement adjustment, ageism, elder abuse, long-term care services and support systems, and neurodegenerative diseases (e.g., Alzheimer's disease) (Roberto and DiGilio, 2016). Keum also highlighted the role counselling psychology can have within this context in addressing the mental health needs of older adults as it is a field specialising in mental health treatment, vocational interests, social justice, and multicultural issues. Yet, older adult research in counselling psychology has been limited (Werth, Kopera-Frye, Blevins, and Bossick, 2003). Werth et al., (2003) examined older adult representation in the *Journal of Counselling Psychology* (JCP) and *The Counselling Psychologist* (TCP) between 1991 and 2000 and reported an underwhelming pattern of interest in older adult issues, with only eight empirical and eight theoretical articles specifically focused on older adults. These researchers do note that counselling psychologists who work and conduct research with older adults may be engaged in interdisciplinary collaborations and as such may not necessarily consider counselling psychology journals as the main outlets of reporting.

Furthermore, proponents have asserted that counselling psychologists possess unique values and strengths in addressing the mental health needs of older adults. For instance, Werth et al., (2003) stated that various concepts core to counselling psychology such as the lifespan focus, the person-environment emphasis, and the vocational theories (e.g. Lifespan View of Career Development Theory; Super, 1980) allow researchers to take a unique lens in attending to the developmental, vocational, and culturally relevant mental health needs of older adults. Further, Nelson, (2006) claimed that one defining strength of counselling psychology has been the social justice agenda to identify unique experiences of diverse populations concerning their well-being. Such efforts have been instrumental in bringing attention to various social issues (e.g. racism, sexism). Thus, the focus on social justice and multicultural issues in counselling psychology has much to offer in examining the complexities of the oppression that older adults face, such as ageism as a significant factor contributing to the oppression that older adults can experience at individual and institutional levels. Whilst these studies provide insightful attributes to counselling psychology, it feels important to acknowledge here that counselling psychology is a multi-faceted discipline that invites all of its practitioners to discover and explore their personal and professional stances within Psychology. As such, there are individual characteristics and beliefs that each practitioner holds. Whilst social justice is at the forefront of the teachings, what aspects or areas of social justice that practitioners will gravitate towards a mixture of personal and professional experiences will likely drive. Not all counselling psychologists will pay attention to, and be aware of the potential oppression of older person's mental health both within the counselling psychology literature and within the literature more broadly.

Keum's (2018) study aimed to assess whether there has been any shift toward greater understanding and integration of older adults and age-related issues in the field of counselling psychology. The study sought to provide an update on the trend and characterisation of older adult research published in major counselling psychology journals since the last review 15 years ago (Werth et al., 2003). Their study reported less than 1% of the total articles in JCP, TCP, and *Neurology and Psychology* (CPQ) were devoted to older adult issues, which they claimed to be a vastly underwhelming number

despite the periodic recommendations and calls for attention on this population in the field of counselling psychology and from Governmental and organisational initiatives.

Furthermore, psychology has long been associated with the concept of compassion. Spandler and Stickley (2011) highlight clinical psychology's emphasis on developing specific "compassion-focused" therapies and incorporating practices of self-compassion through the teaching of meditation and mindfulness exercises (Gilbert, 2005, 2010; Teasdale et al., 2007). These practices promote self-kindness and a profound acceptance of one's present experience and situation. In counselling psychology and psychotherapy, the necessity of "unconditional positive regard" is emphasised in the humanistic psychology of Rogers et al. (1961); Rogers claims a need to maintain unconditional positive regard, empathy and congruence to alleviate suffering. Similarly, the development of a "capacity for concern" is central to Kleinian object relations theory (Froggett, 2002); and the necessity of affiliative relationships is central to the attachment theory of Bowlby (Pilgrim et al., 2009). These are all components similar to Atkins and Parker's (2012) definition of compassion. Spandler and Stickley (2011) note that such literature within counselling psychology supports the contention that compassion is deeply rooted in the heart of what it means to be human and claim that mental health services need to develop and nurture contexts that cultivate such qualities. They summarise that compassion is not another quick fix or technical solution, nor is it a substitute for new therapeutic strategies or systems of care. Instead, they advocate for it to be a foundational quality that pervades all innovations, policies, and practices. They claim that current mental health policy frameworks do not prioritise the development of these qualities because they do not sufficiently address the importance of context. They suggest policymakers and researchers need to adopt a broader understanding of compassion, which could usefully explore whether particular contexts and services are more or less able to facilitate compassionate care.

Thus, older people's mental health appears to be under-represented within the research field of counselling psychology, especially regarding nursing and healthcare support workers working within acute inpatient services. Furthermore, compassion is a concept rooted deeply within counselling psychology theories and as counselling psychologists can

go on to work within the organisational culture within the NHS, it seems relevant to conduct research within this area to inform future initiatives.

Conclusion

West (2021) has claimed that compassion makes a profound difference in outcomes for patients, service users and clinicians and states that compassion may be the most important intervention overall in health and social care. The research, evidence and studies highlighted throughout this review have been somewhat positivist in their approach. The focus of the research has been to demonstrate the positive effect that implementing compassion 'on' staff can have, and the negative effect a lack of compassion can have. Few studies have taken a qualitative approach as a way to attempt further to understand what compassion means for the staff working within the NHS. There have been many initiatives both past and recent that have attempted to create a compassionate workplace within the NHS, such as; *Compassion in Practice* (2012), *Leading with Compassion Programme (2015),* and *Cure the NHS (2013).* O'Driscoll et al. (2018) aimed to evaluate the awareness, involvement and perceived impact of the Compassion in Practice strategy amongst healthcare professionals within England. Through a mixed-methods approach, they found the strategy was limited due to a lack of awareness amongst staff, and at ward level, staff who were aware and involved, perceived a lack of support and communication from senior leadership to deliver the Compassion in Practice strategy. They summarised that results reveal professional anger, distress and resistance to the compassion and practice strategy and a view of the programme as a top-down initiative that did not sufficiently recognise structural constraints on nurses' ability to deliver compassionate care.

The current, South Wales initiative; *A Healthier Wales* also looks to create compassionate leaders within health and social care as a way of disseminating compassion throughout services. This initiative, like previous initiatives, has failed to hear the voices of staff working within these services. Hence, from a counselling psychology, and critical realist perspective, this research aims to further understand how the nurses and healthcare support workers within the NHS, specifically, older persons' mental health inpatient services, understand, make sense of, and experience compassion. I believe that we can only identify the most effective ways to support these staff members in their challenging

work by comprehending how they perceive, discuss, and understand compassion within their specific environment. How can we aim to foster a compassionate environment when we lack insight into their prevailing perceptions, discussions, and understanding of compassion within that context?

Rationale for Study and Research Aims

Rationale

The Parliamentary Review of Health and Social Care in Wales (H&SC) (2018) highlighted the necessity for change in health and social care provision, and argued that there is a need to bring health and social services together with a focus on the needs of individuals and a greater emphasis on wellbeing (HEIW, 2020). '*A Healthier Wales: Our Workforce Strategy for Health and Social Care*' is a long-term workforce strategy that sets out the vision, ambition and approaches that put wellbeing at the heart of the plans for both Health and Social Care in Wales. The 10-year plan revolves around the goal of creating an inclusive, engaged, sustainable, flexible, and responsive workforce in H&SC, as outlined in the Parliamentary Review (2018). Whilst this initiative considers health services as a whole, there is a focus on improving integrating services, co-production and holistic approaches to treating physical and mental ill health. '*Together for Mental Health*' is a Welsh Government strategy that seeks to implement these improvements alongside '*A Healthier Wales workforce strategy*' within mental health services across Wales (Cymru.gov.uk, 2020). Health, Education, and Improvement Wales (HEIW) (2020) claim that this workforce strategy is the opportunity to develop a compassionate culture with a focus on creating leaders who demonstrate collective and compassionate leadership. West (2017) claims that compassionate leadership drives compassionate care. Current initiatives within Wales' Health and Social Care seek to create services that focus on the needs of individuals and place priority on wellbeing. This initiative builds upon the concept that fostering compassionate leaders within healthcare can and will lead to the development of a compassionate culture, as suggested by West in 2017.

In cases where health service staff confirm having compassionate leadership, patients also report receiving respect, care, and compassion (Dawson et al., 2014). As such, the current workforce strategy is placing its focus on creating compassionate leaders within the NHS, taking more of a top-down approach. However, this initiative has neglected to hear the voices of the staff who work on the frontline of mental health. This research study, therefore, was designed to take a bottom-up approach and to speak to staff working on Older People's Mental Health wards within Harborview Health System .

Giving voice to those who provide constant care for older adults with complex mental health symptoms and/or dementia symptoms can help us to attend, understand, empathise and help to increase their well-being, job satisfaction and compassionate care, with the view to improving the quality of care given. A better understanding of their experience and views of compassion within the workplace can help inform the current workforce plan for developing a compassionate combined health and social care workplace.

Research Aim(s)

This research thesis was designed to gain a greater understanding of mental health nurses' and healthcare support workers' experience of working in an older person's mental health in-patient ward in Wales. This study aimed to explore nurses' experience and awareness of their personal, professional and organisational compassion, and, their views on how this may affect both patient care and job satisfaction.

Research Questions

This study addresses the following research questions:

i) How do nurses and healthcare support workers understand and make sense of compassion?

ii) What is their personal and professional experience of compassion within the health board and over their career?

Methodology

Design

All participant's, the ward names, and the health board name mentioned throughout the thesis are pseudonyms in order to protect the anonymity of participants.

A qualitative methodology was determined to be the most appropriate fit with the research aims, using interviews to gather data from nurses and healthcare support workers working within an older person's mental health inpatient ward in Harborview Health System. I transcribed data collected from interviews and chose reflexive thematic analysis (TA) as the analysis method, following Braun and Clarke's approach (2006, 2022).

Qualitative methodology is well suited for exploring complex and multifaceted psychological phenomena, like compassion. It allows for in-depth examination of experiences, perceptions, and behaviours and offered flexibility in data collection methods. Further, qualitative research places a strong emphasis on understanding the perspective of participants. This is crucial in counselling psychology, where the lived experiences and voices of individuals are central to the research inquiry. (Creswell et al., 2007)

As a researcher within the counselling psychology discipline who is new to qualitative methodologies, thematic analysis initially offered me, space to understand, learn and reflect on my ontological and epistemological beliefs, both within and outside of research. As I discuss below, in my reflexive statement (page 47), whilst I was sure of my qualitative approach based upon my research questions and aims, I was less clear on what my philosophical positioning was in relation to this research. The flexibility of thematic analysis allowed me time to explore this whilst I considered the relationship between my philosophical beliefs with compassion and within this research project. The flexibility in thematic analysis allowed me the freedom to choose what my genuine and actual philosophical beliefs were, as it allowed me space to reflect more positivist as well as more contextual which provided me with a clear rationale as to why I then landed on a critical realist position.

Interviews were chosen as the method for collecting data as they allow for a rich, in-depth exploration of the research topic (Braun and Clarke, 2013). Interviews allow an opportunity to probe deeper into participants' thoughts, feelings and experiences, providing a more comprehensive understanding. Further, interviews provide an opportunity to understand the context surrounding participant's experiences, which, given my critical realist stance, felt important to me. I was able to ask follow-up questions to gain insights into the social, cultural, or environmental factors influencing their compassion. Interviews also offer flexibility in adapting questions based on the participant's responses. I could modify questions or explore unexpected avenues, making the process more dynamic and responsive to emerging insights. Additionally, Interviews allow researchers to capture the participant's perspective directly (Stelter, 2010), this was an important factor for me, as I wanted to capture and understand participants' subjective experiences. Face-to-face interviews, both virtually and in person provided an opportunity for me to establish rapport with participants. Rapport within research interviews can lead to more open and honest responses, contributing to the trustworthiness of the data (Johson, Adkins and Chauvin, 2020).

Theoretical Standpoint

Woolfe, Dryden and Strawbridge (2003) claim the philosophical underpinnings of counselling psychology are rooted in humanistic, existential and phenomenological values that strive to explore understanding and meaning whilst holding subjective experience and beliefs at its core. As in psychological research, in psychological practice, there are many stances, beliefs and approaches that a psychologist can hold. As a pluralistic counselling psychologist, I view mental health as a concept that has many meanings, theories and understandings. I believe that its symptoms provide insight into the reality of mental health and that through language we can communicate and understand these symptoms and experiences. The language that is used and how the language is interpreted and understood by others will all be dependent on a person's social, cultural, conscious and unconscious experiences. That is to say, two people who describe similar symptoms may interpret, understand and hold different beliefs about their symptoms, but both experiences are equally real to each person.

As such, this research is broadly experiential whilst being underpinned by a critical realist perspective (Wiltshire and Ronkainen, 2021). Experiential approaches aim to capture participants' experiences and perspectives and ground research in participants' accounts, rather researcher's categories, but view language as a reflection of "internal categories of understanding" (Reicher, 2003: 3). A critical-realist perspective pays attention to and explores how individuals make sense of their personal experience and understanding, whilst also considering the broader social context and how their representations of their reality may be characterised by this (Maxwell, 2012). It is assumed that participants will have insight into their own experiences, but that these insights may be shaped by the culture of the hospital ward and the social interactions within that environment, as well as their own culture, language and political interests (Braun and Clarke, 2023).

Developing the interview guide

To start, a list of questions relating to the areas of compassion, older person's mental health and the NHS were explored. From here, I attempted to create a sense of structure within the interview guide. Braun and Clarke's (2013) suggestions of areas to consider when designing interview guides were held in mind: opening and closing questions, sequencing of questions, constructing and wording questions, prompts and probes, research questions are not interview questions, and finally, social desirability and are discussed below.

The interview guide had to be developed quite soon into the research process with Integrated Research Application System (IRAS) ethical approval requesting a draft version of the interview guide. At this stage in the research process, I was spending a lot of time reflecting and researching my ontological and epistemological views, which inevitably shaped my research questions. Initially, questions that *set the scene* were broader and general questions regarding what participants felt it was like to work within the NHS, what they felt it was like to work within OPMH inpatient services and how they felt they were treated as a member of staff within the NHS. These topics were included as once I had grasped what compassion meant to each participant, I wanted to explore and analyse this with relation to how they had described working within the NHS and working within OPMH inpatient services. Topics then moved on to explore some of the rewards and challenges that staff members face within this area of work, which again was to grasp the

context in which they worked and their opinions and views of the ward in which they worked so that how they then viewed compassion was held within that context they had described. The final 'section' of the interview guide was the compassion-specific questions. These questions were broad and open in that I wanted to hear what they felt their experiences of, and lack of, compassion were, as a way to also understand what compassion meant to them. My interview guide was crafted with a theoretical foundation rooted in experiential critical realism. It intentionally avoided assuming a uniform perspective or singular 'reality' of compassion among participants. Instead, it provided ample space for the exploration of diverse viewpoints influenced by the unique contexts of the ward, participants' cultural backgrounds, upbringing, and personal subjectivity. This approach allowed for both explicit and implicit discussions surrounding the chosen topic, compassion. Please see Appendix A for the completed interview guide.

Recruitment

Pseudonyms are employed to safeguard the anonymity of participants, including the health board, wards, and individual names. Convenience sampling was used to determine which health board and which inpatient wards would be identified and selected for recruitment. Harborview health system is one in which I have worked for the past six years. Older person wards were chosen within the health board due to the current initiative detailed above; within this initiative, a focus is on mental health services. The complexities of dementia care along with mental health care that nurses and healthcare support workers often work with, as mentioned in the previous chapters, it was determined to be a good place to focus the research.

Participants were recruited via service managers. A flyer/poster (see appendix B) to advertise the study and to ask for staff to participate was sent to the service managers who then passed these on to the ward managers. Ward managers displayed the posters, sent out emails to all staff and verbally informed staff of the study during handovers and meetings. Two ward managers from two different wards invited me to their wards and provided me with a private room for me to conduct interviews. Once one or two staff members had volunteered to participate, snowball sampling was used to continue to recruit further staff members. After multiple attempts of recruiting on the remaining two wards with no success of recruitment, contact was made with the assistant psychologist

who agreed to place further posters around the ward, where two members of staff, from the two remaining wards made contact via email requesting to participate in the study.

It was decided early on in the ethical approval stage of the thesis that consent to participate would be collected verbally only and would be done at the start of the interview, following a consent form (see appendices D) that would be sent or read to the participant. Participants' verbal consent to participate was audio-recorded. This was decided as there were various methods of interviewing being offered to participants (face-to-face, online and telephone) and so verbal consent felt consistent and efficient across all methods. It was hoped that by consent only being verbal and not written, and with interviews being conducted through various methods, an increased level of felt anonymity would help with recruitment. Those who wished to participate during work time and who preferred in-person could choose that option, but those who wished to participate away from work and to feel more anonymous could request a phone call. Two participants opted for video call and all other interviews were conducted in person within work time.

Due to the qualitative nature of the research and given that data generation method was interviews, information power, as stated by Malterud, Siersma and Guassora (2016) will be referred to. The concept of information power in qualitative research highlights the notion that a sample possessing rich, relevant knowledge related to the study's focus can potentially reduce the need for a large number of participants. This principle is particularly pertinent in the context of interviews. Interviews facilitate direct interaction with participants, enabling in-depth exploration of their experiences and perspectives. The planning phase involves an initial estimation of sample size, but information power emphasises the necessity of continuous evaluation throughout the research process. Researchers must assess the adequacy of the sample size by considering the depth of insights gained, the saturation of themes, and the ongoing contribution of participants' information. In interview-based studies, the selection of participants with diverse and pertinent knowledge is crucial, and researchers should adapt their approach as the study progresses to ensure the richness and relevance of the data collected. The initial aim for

interviews was between 10 and 15, and the total number of interviews completed was 14.

Participant information

The study exclusively recruited participants from Harborview Health System, where they served on wards dedicated to individuals aged over 65 facing challenges associated with dementia and/or distressing mental health symptoms. The participant cohort consisted of nurses and healthcare support workers, with one inclusion being a student nurse presently engaged in an older people's mental health inpatient ward within Harborview Health System. The nursing staff included various roles, such as staff grade nurses (band 5), clinical lead nurses (band 6), and nursing ward managers (band 7). For a concise overview of participant details, refer to Table 1.

Table 1: Participants' Demographic Data

Ward	Eirys Ward (1)
	Ffion Ward (6)
	Menyn Ward (6)
	Lili Ward (1)
Age Range	26 - 34 (2)
	36 - 44 (5)
	45 - 49 (2)
	50 - 54 (3)
	55 - 57 (2)
Job Role	Ward Manager (1)
	Clinical Lead (1)
	Nurse (3)
	Healthcare Worker (8)
	Student Nurse (1)
Gender	Male (4)
	Female (10)
Length of Service	≤ 5 years (5)
	6 - 10 years (3)
	11 - 20 years (1)
	≥ 20 years (5)

Ethical consideration

Ethical approval for this study was granted by the University of the West of England, Health and Applied Sciences Faculty Research Ethics Committee (FREC); as well as receiving approval to interview NHS staff via the Health Research Authority (HRA). Before each interview, participants were asked to read the participant information sheet (see Appendix C), which detailed the nature of the research study, what participation involved, and the uses to which their data would be put. I obtained verbal informed consent from each participant through audio recording before commencing the interviews (see Appendix D detailing informed consent). As the interviews delved into participants' self-

compassion and their experiences related to their work and the delivery of care, there was a possibility that some participants might be hesitant to share certain information out of concern for how it could affect their careers. To address this, it was essential to establish strong rapport with participants and maintain a high level of confidentiality and anonymity wherever possible. In the event that a participant experienced distress during or after the interview, I was prepared to provide support through the health board's wellbeing services. All participants received information about these services and were encouraged to reach out for any support they might require. Additionally, participants had access to the contact information of my director of studies (DOS), whom they could reach out to if they found themselves in distress, as a result of their participation in the study. My DOS is a psychotherapist with over 30 years of experience as a clinical psychologist within the NHS.

Data analysis

Data collected from interviews were analysed using Braun and Clarke's (2022) approach to TA, which included the following six phases:

Phase one: Familiarise yourself with the data. Initially, the automated transcripts that were generated via Microsoft Teams during the interviews were used as a basis for transcribing the audio capture of the interviews. Due to there being many grammatical and structural errors within the transcribing, I found that it was easier to transcribe them myself, this allowed me to focus on what participants were saying, and how they were saying it, as opposed to being caught up in looking for errors and making corrections whilst transcribing. This, I felt began the immersion phase where I spent time repeatedly reading and listening to the data within the interviews. From this, I began critically engaging with the data, that is, I started to acknowledge and notice how I felt and reacted to the data, whilst also considering the different aspects, perspectives, and underpinnings of what each participant might be saying at different points and topics within the interview.

Phase two: Doing Coding. Initially, coding started at a semantic level, generating codes based on participants' explicit expressions. After reading each data section with intent and attention, I would assign a code label to any segments that I believed held potential

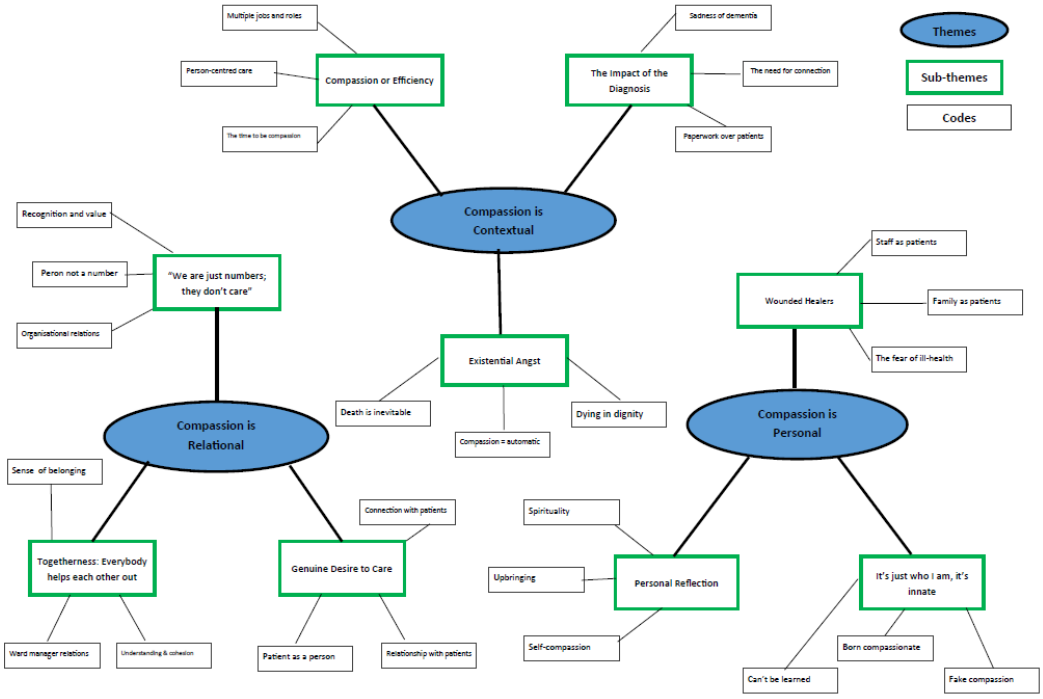
relevance to my research questions. As the coding process evolved and my code labels became more refined, I transitioned to coding at a deeper, latent level. This involved capturing implicit meanings and understanding, from which I created corresponding codes. Within this phase, I used both paper and electronic versions of my data to generate codes. I found that switching between the two modes helped me to read and feel differently about the data as my mood, energy, time of day and location changed. Initially, I felt overwhelmed by the number of codes that I had produced and felt the easiest way for me to manage, organise and continue to analyse the codes further was via a Microsoft Excel spreadsheet. Initially, I listed codes for each participant in separate tables and then began 'grouping' codes together that shared similar meanings. These refined codes were entered into a new table and this process continued until I felt as though I was ready to move on to the next phase (An example of this coding process is within the appendices E).

Phase 3: Generating initial themes. This phase entailed organising codes into potential themes across the dataset. Initially, I believed I had created themes that effectively captured the dataset. However, upon reflection and in discussions during supervision, I recognised two key issues: first, I had initially created an excessive number of themes, and second, I had primarily organised codes and provided labels to summarise them, rather than truly conveying the narrative of my data in relation to my research questions. After some back-and-forth between phases 3 and 4, I decided to prioritise grasping the narrative of my data before delving into the further development and review of themes. Once I felt that I had a firm understanding of the data's story, I then proceeded to phase four.

Phase 4: Developing and reviewing themes. During this stage, time was spent to ensure that initial themes that had been created respectfully captured the story that was within the dataset across participants. Initially, I felt that I had moved into this phase too quickly and that I needed to revisit phase three. Following this, I found it helpful to map out my codes and initial themes (See Figure 2 of the thematic map created). This helped me to visually see the relationship between my codes and initial themes, it allowed me to look

at the themes that I had created whilst holding my research question in mind and whilst also considering the participants and their story and the meaning behind the codes.

Figure 2: Thematic Map



Phase 5 – Refining, defining, and naming themes. At this point, it proved invaluable to craft comprehensive definitions and narratives for each theme. During supervision, it became apparent that the original theme titles lacked depth and failed to encapsulate the nuanced story within the data; instead, they appeared broad and distant, resembling mere summaries of the words used in the codes. Consequently, a substantial amount of time was dedicated to refining theme titles and sub-themes to ensure that they had a good fit with the data within. In some instances, themes incorporated direct quotations from the participants, imparting a sense of proximity to the accounts shared by the participants.

Phase 6: Writing up. Braun and Clarke (2022) explain the importance of this phase as not being an "add-on to analysis" (page 118), but one where you are still analysing the data as you write it. This phase, they describe as "deep refining analytic work to shape the detail and flow of the analysis" (page 18). Direct participant quotations were used to help

capture the narrative, which was discussed through research supervision where the relationship between participants' narratives and analysis was discussed.

Reflexivity is a vital aspect of thematic analysis, and as someone who has been employed by Harborview Health System for the past five years, it was of great importance throughout the research. Finlay and Gough (2008) described reflexivity as routinely reflecting on assumptions, expectations, choices and actions throughout the research process whilst also acknowledging the impact that these assumptions and experiences can have on the research outcome. Mortari (2015) stresses the importance of reflexivity being visible to the reader. I will now explore my relationship with the research topic and my personal background.

Personal Aspect:

Insider and outsider

I perceive myself as occupying a dual role, straddling the realms of both insider and outsider perspectives. On one hand, I embody the insider perspective due to my prior employment as a support worker in a mental health context. This experience has afforded me valuable insights into the dynamics of support work. On the other hand, I also maintain an outsider stance. While my role as a support worker did provide me with relevant experiences, it occurred outside the scope of the NHS within a residential setting catering to a distinct demographic of individuals, which notably did not include older adults. Furthermore, this experience unfolded during a different time period pre-ward restructuring, further emphasising my outsider status in relation to the specific context of this study.

Further, my dual insider/outsider perspective applies to my time working within the health board. My insider role stems from a period of over a year during which I worked on the same wards that participants were recruited from, but as an outsider, as my experiences of working on these wards were in the capacity of an assistant psychologist and not a nurse or HCSW. This experience allowed me to gain insights into the roles of support workers, recruitment and training processes, and the challenges I encountered

during my time in that role. Moreover, my work as an assistant psychologist on these wards provided an opportunity to observe and learn about the responsibilities of nurses and health care support workers. I also had the chance to share experiences related to behaviours that challenge dementia and to gain valuable insights into the policies, structure, and management of the wards. It is worth noting that at the time of conducting the interviews, I hadn't worked on these wards for over three years, during which time many staff members had left or retired, and new staff had joined. Additionally, the wards had undergone significant changes following the advent of COVID-19, further altering the landscape. As I approached the interview phase of my research, I found that my experiences, the staff members I had worked with, and the management on the wards had all undergone considerable transformations.

Furthermore, my lens of perception in this research context is grounded in a critical realist, psychological perspective. I acknowledge that my experiences and perspectives may differ significantly from those of other staffing groups and even fellow psychologists working on the wards. The intricacies of how I view mental health, social dynamics, and systemic processes are all filtered through this specific lens, which highlights the importance of recognising potential differences in my interpretation and understanding of the ward environment.

In addition, as an employee of Harborview Health System, I hold views and judgements as to what compassion in relation to the health board means to me and what my experiences of this are. As someone who has a manager and work colleagues whom I would describe as being very compassionate, supportive and helpful, I would describe my experience of compassion within the health board as a positive one. I have experienced support, value, and respect throughout my time there. I do acknowledge the stress and pressures that both my colleagues and I have faced while working within the health board. I have personally encountered situations where the organisation's lack of compassion was evident. For instance, psychology received funding to establish a specialised Community Dementia Support Team, which gathered remarkably positive feedback from the public, patients, and service users. However, this initiative came to an

abrupt end when the government and senior management decided to redirect the funding to another service, discontinuing this successful endeavour. I have experienced the politics and sometimes seemingly unnecessary rigid structures of the NHS that can leave clients and patients being ''bounced'' between services and not being treated with compassion, and I have heard from clients who have experienced a lack of compassion throughout their journey within the NHS.

Further to this, it seems important to explore and state my identities. My interpretation does not solely stem from my professional experience or disciplin; it's also shaped by my background. I identify as a young, white, heterosexual, working-class Welsh woman. The challenges I faced in my childhood and my life experiences, as well as my interactions with people, significantly influence how I perceive, interpret, and comprehend compassion. Consequently, it is crucial to be aware of and understand all these aspects. I have deeply reflected on these factors throughout my reflexivee process, which I will discuss further throughout my reflexive process.

Reflexive process:

An intervention that encourages reflexivity and allows thoughts and perceptions to be captured, thereby developing my understanding of my role in the research, is a research diary (Parker, 2005). Throughout this research, I kept a research diary, which allowed a place for me to become self-aware of any thoughts, emotions, and feelings that influenced my behaviour within interviews, but also how I viewed, shaped and created themes throughout the data analysis. During my training as a counselling psychologist, I have undergone great self-reflection through the teaching I received and learned to understand my subjectivity, through the many hours of personal therapy I have completed, and through my placement and work within many NHS services. Throughout our course, our tutors consistently emphasise that we are inherently subjective beings, influenced by our prejudices, expectations, judgments, reactions, and personal experiences. When we step into the therapy room with a client, we carry all of these aspects with us. We are encouraged to delve into this self-awareness to comprehend the

dynamics of transference and countertransference, our intra-psyche defences and how they manifest and interact with the client within the therapeutic space. I have applied this concept of self-awareness and self-reflection to my role as a researcher. My research diary is not merely a collection of research notes; it is an inseparable part of me that encapsulates who I am and how personal situations influence my thoughts, emotions, and behaviours—both consciously and subconsciously—throughout my research journey. Consequently, I have made a concerted effort to remain open and inquisitive, continuously exploring my subjectivity. This allows me to be aware of it and acknowledge its presence, not only within my research but also in all aspects of my life.

One example of where I became aware of my pre-determined expectations of interviews and where reflection was important and helpful was following the completion of my first two interviews. The first interview was completed online with a nurse working on a particular ward within the health board. I was aware before the interview that I had expected the nurse to reflect negatively about her experience of compassion on that ward and that this expectation was due to my inside knowledge from working within the health board and having an idea of the difficulties that the ward was facing. This was a reasonable reflection of the data captured within that interview. Going into the second interview with staff from a different ward, I assumed and expected staff to reflect on something similar in terms of their experience being negative. The staff, however, spoke of experiencing compassion from the ward manager and her colleagues and spoke of the positive impact that this had on their ability to be compassionate; this was despite the ward also experiencing similar issues of low staffing and challenging behaviours. I became aware during the interview of feeling stuck, as I had not expected this response. Post-interview, I reflected on this and became more aware of what I was thinking, feeling and what my opinions were of the wards and the service as a whole, based on my experiences and inside knowledge, despite there being new staff members, new management and a new ward structure. This allowed me to go into the next interview and the interviews that followed with more of an open mind. I was able to recognise what were my opinions and thoughts, and I was able to be more curious and genuine in my approach in the interviews, which I believed helped me to form a rapport with participants and aided them in also being open and honest with their responses.

Analysis

Analysis of the data relating to participants' descriptions of compassion resulted in the development of three overarching themes, see the below table 2:

Table 2:

Theme	*Subthemes*
Compassion is Relational	We are just numbers, they don't care Togetherness: "Everybody helps each other out" Genuine desire to care
Compassion is Contextual	Compassion or Efficiency The toll of caring: Compassion fatigue in dementia care Existential angst
Compassion is Personal	Wounded Healers The Compassionate Self: Mindfulness, Empathy and Self-Reflection "It's just who I am, it's innate"

The first theme, *Compassion is Relational*, includes how compassion influences and shapes relationships with patients, colleagues, managers and people in general. Within this theme, three subthemes were created: i) "We are just numbers, they don't care; ii) Togetherness: "Everybody helps each other out"; and iii) Genuine desire to care. The second theme, *Compassion is Contextual,* highlights how compassion can vary between cultural, social and individual factors, and how it can also be affected by environmental and situational factors such as workplace ambience and the nature of the diagnosis. Within this theme, three subthemes were created: i) Compassion or efficiency; ii) The impact of the diagnosis; and iii) Existential angst. The final theme, *Compassion is Personal,* includes a person's experiences, beliefs, and values and how these can shape and determine their ability to form self-compassion. Within this theme, three subthemes were created: i) Wounded healers; ii) Personal reflection; and iii) "It's just who I am, it's innate.

Compassion is Relational

When talking about compassion and what it means to them, what it looks like, and what it feels like, participants spoke of "connection", "mutual respect" and "understanding" as factors that affected the level of compassion they felt. Participants viewed taking time to build relationships as fundamental to compassionate practice. As human beings, we are intrinsically relational (Melé et al., 2014) and research has highlighted the significance of our relationships and the impact that they can have on our well-being (Means and Cooper, 2017). All participants spoke of different aspects of developing and maintaining relationships with colleagues, patients and their families, and how these relationships impacted their compassion. Specifically, participants discussed how a lack of connection with senior management meant that they felt a lack of compassion from senior management, but if they then felt they had support, respect and understanding from their ward manager, this harnessed a sense of togetherness on the ward. This togetherness resulted in an increased level of compassion between the staffing team, which in turn, also impacted their ability to maintain their compassion towards the patients. Some participants explained that they entered the field of care because they enjoyed meeting new people and interacting with others in general, but that they found it difficult to maintain compassion for their colleagues and sometimes their patients due to various factors, such as experiencing a lack of connection, support and respect from ward managers and their senior management. This theme captures the relational aspects of compassion, how compassion can create a sense of relational connection, but also how compassion can be felt through experiencing relationships. Three sub-themes were constructed which highlight the different relationships that participants described as impacting their compassion: 1) We are just numbers, they don't care; 2) Togetherness: Everybody helps each other out; and 3) Genuine desire to care.

Subtheme 1: "We are just numbers, they don't care"

When asked about the level of compassion that participants felt from the organisation, nearly all participants spoke about experiencing a lack of compassion from their senior management. This lack of compassion was evident in the fact that they had little or no relationship and interaction with their senior management. These participants discussed how the role and the level of input senior management had on the wards had changed

over time, with three participants reflecting on their time within the NHS for over 20 years. Participants discussed feeling as though senior management did not develop relationships with staff on the wards and that a lack of presence from senior management impacted their level of felt compassion from them. Participants spoke of senior management as being both physically and cognitively distant from staff and from the wards in general, and that they felt as though they were just a number and not a person in the eyes of senior management. The data extracts below illustrate that when there is a deficient connection with senior management, senior managers tend to lack awareness of the ward's activities. Additionally, a lack of respect contributes to senior management not personally knowing the staff. This situation leaves participants feeling perceived as mere numbers rather than individuals:

> "They'd [management] come on wards, turn up and not looking, or to be looking for anything, but just for a chat, just passing, but now, they don't, they just seem to be concentrating on too much and aren't showing older persons compassion." (Chloe, ward manager, Ffion ward)

> "It's the top I feel that don't come and see the ward very often and don't see how it is. And how hard we work. I think they need to come down and see the issues on the ward, I think they make the wrong decisions, the top bosses because we never see them, I think that's a bit of respect and you know, seeing how the ward runs." (Sarah, Healthcare support worker, Ffion ward)

> "There used to be more [compassion] than there is now. Management changed over the years, I notice it's not as good as what it was, because we used to see the hospital manager on a daily basis and she knew your name, or he would know your name, at the moment, I don't think, the one we got now, doesn't know us personally". (Anne, Healthcare support worker, Menyn Ward)

These quotations from three different participants with two different job roles highlight the importance of the felt presence of senior management when developing a relational connection with, and feeling compassion from, others. When asked about the level of compassion that participants feel they receive from the organisation, all three participants above spoke about the lack of presence they felt senior management had on the wards and the impact that this had. Sarah spoke about how presence demonstrates respect towards staff and enabled senior managers to gain an understanding of issues and staff work ethic. Anne discussed the importance of presence as a way to get to know staff, and how she feels that her senior management not knowing her personally means there is less compassion than there was before when senior management used to visit

the ward daily and would know staff names. Anne is reporting the importance in having an aspect of relational depth with senior management, which, as a result, would create a compassionate relationship. Finally, Chloe discussed how a lack of senior management presence on the ward does not just result in her feeling as though there is a lack of compassion, but that it causes the service as a whole (i.e. the staff and patients) to feel that lack of compassion. What participants are suggesting here, is that firstly, they may feel more compassion from higher management if senior managers created some form of a relationship with them, and secondly, that this relationship may be formed merely by having a physical presence on the ward and by taking time to engage with staff.

When asked about a time when Chloe had felt compassion from the organisation, she initially described a recent time during the COVID-19 pandemic, when she felt as though staff, the public and the senior management had pulled together to all support each other; however, as demonstrated below, the compassion shown by senior management was questioned:

> "When we were in COVID. Was it full compassion? Or was it because of their job role…because they weren't on our front line with us, apart from one, and to be honest she shown really high compassion, as for the others, nobody would come on the wards, a lot of senior management were working from home and we felt that. And it's not just me, all of us felt the same, they aren't seeing what we are going through, they're not understanding. Okay, they gave some leeway with overtime and things because so many people were off, but other than that, I don't think they've shown compassion. Apart from the psychologist that came on the ward, they showed compassion, the priest, bereavement people, they came on and showed compassion, the general public coming to the doors to bring us something – showed more compassion than our senior management did. And I think that's why people are leaving because people felt let down because they didn't show that full compassion". (Chloe, Ward Manager, Ffion Ward)

Chloe highlights the significance of senior management fostering a connection with and through this showing compassion to staff. Elements of this relationship would include presence, understanding, and support for the staff members. Chloe discusses different aspects of what support would cover, such as giving leeway with overtime, having a physical presence and providing staff with items and kindness. I have interpreted this to the behavioural and 'action' aspect of compassion, where compassion is understood as 'acting' to alleviate suffering. Such a relationship would not only bestows compassion upon Chloe as a ward manager but would also generate a positive influence more

broadly, benefiting the staff working on the ward, the service as a whole, and the patients who utilise it. Chloe's account is supportive of research that highlights aspects of compassion as being empathetic, understanding and having concern for others whilst also encompassing an individual's internal emotions and attitudes (West, 2021), which are similar characteristics to aspects of forming relationships such as empathy, congruence and positive regard (Rogers, 1957). Chloe also highlights the potential impact that a lack of relationship, and as such compassion, can have on staff when she suggests it has caused staff to leave their job, due to feeling let down by senior management. The next subtheme demonstrates this further in the way that staff discussed their relationships with their colleagues and their ward managers and the aspects of these relationships that they found both helpful and unhelpful when developing a relational connection and how this impacted their compassion.

Subtheme 2: Togetherness; "Everybody helps each other out"

During interviews, participants discussed the importance of teamwork and team cohesion and the impact that this can have on their well-being and overall happiness whilst at work, which inevitably impacted their ability to remain compassionate towards patients. Compassion has been found to serve as a vital pillar for building and nurturing connections (Mitten, 2017). Participants discussed how compassion creates an atmosphere of safety, trust and support. Furthermore, when discussing their experiences of compassion from colleagues on the ward, all participants discussed how compassion fosters a sense of belonging and mutual care by understanding and validating each other's emotions and experiences. The following data extracts demonstrate some of the responses during interviews when discussing participant's experience of compassion from colleagues on the ward:

> "I've have had various physical ailments in the past, quite serious, and I've got to go off sick for operations, and I was supported really well by the team, both at the time when I was waiting to have an op and I was able to work and then post op as well. You know, they called by the house or just the odd phone call here and there. Yeah, it is a really good team". (Nathan, Nurse, Ffion ward)

> "My colleagues are quite compassionate. A lot of the time, they understand that you know, I'm under a lot of pressure with, like, work and stuff. So, like, they'll offer to write in some notes and then I countersign and things like that, they can be quite thoughtful". (Katie, Nurse, Eirys Ward)

> "Yeah because a lot of staff here are really understanding, if you're feeling down or if you've had a bit of a busy shift, you can offload it outside of work and inside of work, so, the staff are very good here. You know if somebody comes in and their not feeling right, everybody else will step up, and that person might not be doing as much work, because they're not feeling right that day but everybody else will pull together and help out, you know. Everybody comes in and has bad days or if they're feeling ill, or what have you, if something happened, some people won't have to go off sick because they can get through because the rest of the staff have been able to help them get through the rest of the shift". (Sam, Health care support worker, Ffion Ward)

These data extracts provide examples of what compassion means to these participants when thinking about compassion from and with their colleagues. One key aspect of compassion throughout these examples is emotional intelligence. Emotional intelligence is defined as the ability to understand and manage your emotions, as well as recognise and influence the emotions of those around you (Salovey and Mayer, 1990). West (2021) highlights the importance of emotional intelligence when forming relationships. West suggests that recognising and understanding others' emotions helps one to successfully manage relationships, recognise the reciprocity integral to healthy relationships, make time to listen, as well as to share openly. Nathan's example of compassion from his colleagues describes a time when he felt supported and looked after by the team during a difficult time in his life. His colleagues took time and action (through telephone calls and home visits) to support him. Katie demonstrates her colleagues' understanding and appreciation of her stress and busyness levels, resulting in their proactive efforts to alleviate her stress, which she believes demonstrates their compassion towards her. In Sam's case, he emphasises the significance of off-loading and engaging in open conversations with his colleagues. In return, his colleagues serve as attentive listeners, providing him with the essential support he needs. Sam's example also displays his capacity to empathise with his colleagues' emotions and circumstances. This mutual understanding fosters a collaborative spirit among his colleagues, who unite to support each other, particularly during challenging moments. These responses provide examples similar to the aspects of organisational compassion described by Atkins and Parker (2012), in which they claim there to be four components: attending, understanding, empathising and helping. As such, these examples suggest that participants recognise these four components as crucial aspects of compassion. They also contribute to the

formation of a supportive and compassionate team culture within the work on a hospital ward.

Participants also reflected on the amount of compassion they felt that they received from their ward manager and the impact that this can have on their job satisfaction and, consequently, their ability to maintain their compassion towards colleagues. The variation of compassion received and the impact of this is demonstrated below:

> "We've always said that like if we had a different manager and things are fair on the ward, then a lot of us will have more time and we wouldn't feel like coming to work is such a chore and I think people do find like it's just a chore, there's a lot of favouritism. As soon as they walk through that door is like, a dark cloud and they just don't wanna be there anymore, you know. Management just sees you as a number these days. So you just, you know, not like a person behind the number." (Hannah, Nurse, Lili Ward)

> "A lack of compassion, probably from the ward manager, is a big thing, a massive thing. Umm. Not very compassionate whatsoever. I don't think the staff are treated very fairly. In different things like you know in child care and things like that, just like, well, you know, tough basically, you shouldn't be like that, you know, we're all here to support each other. Umm, there's a very, very low morale within the ward, but there has been since the start. It's just got gradually worse. It's sort of like a hierarchy of management, so like, even though management is a hierarchy, there should be like a level of respect, like throughout. But you do find that there's not." (Katie, Nurse, Eirys Ward)

> "Luckily, as I say, we got a good team. I haven't always had that over the years, but we have now, which is nice. The ward manager is very approachable, and amenable which obviously helps because at the end of the day, it's your job and you wanna work what you can, if you got a manager that's amenable that way then it's less stress on you isn't it?" (Simon, Health care support worker, Ffion ward)

The clear contrast between Hannah's and Katie's opinions and emotions compared with Simon's highlights the impact that a compassionate manager can have. Hannah and Katie both discuss a lack of understanding through not being seen as a person and feeling unsupported during difficulties within their personal life and a lack of fairness amongst staff within the wards. Both discuss the impact that this has on staff morale with Hannah demonstrating the impact a lack of compassion can have on their job satisfaction and wellbeing within work. Simon's reflection on compassion from his ward manager discusses how being approachable and open are examples of compassionate leadership and that this can cause less stress on him as a person within work.

One participant, a ward manager, reflected on their perspective of what it means to be compassionate towards the staff they manage:

> "I am compassionate towards the staff, I do understand, yeah. I suppose I am a bit of a soft manager actually, because I give a little leeway for things. You know, if it's childcare last minute, I'll say look, and I've spoken to HR about this, I'll say have special leave day, because I know I would be panicking and my anxieties would be so high and I don't want them to feel like that so." (Chloe, Ward Manager, Ffion ward)

Chloe makes a clear association between being compassionate and understanding staff's emotions and experiences and wanting to do something to help. It is notable to observe Chloe is framing of her management style as 'soft,' which may carry a subtly negative connotation. This choice of language implies that she perceives her approach as potentially undesirable, possibly characterising herself as a pushover. This could indicate a socialisation into a cultural context where there is a prevailing notion that being a 'hard' manager is more favourable or esteemed. When we contrast Chloe's approach as a "soft" manager who allows for flexibility and demonstrates understanding with Simon's perspective, where he regards Chloe's staff team as "good" and characterises Chloe as a compassionate leader, it reinforces the core principles of West's initiative within the health board. This initiative places a strong emphasis on cultivating compassionate leadership within organisations, with the aim of ingraining compassion into the core values of the organisation and propagating it throughout various staffing groups (West, 2021).

When Chloe was asked if she believes that her compassion towards staff impacted their ability to be compassionate, Chloe responded with the following:

> "I like to think so. I think if I'm treating them in that way, they would treat others as well, but not everyone is like that because some people are quite selfish and there are one or two that are like that." (Chloe, Ward manager, Ffion ward)

Chloe offers a slightly critical lens on the above initiative as she identifies that whilst being compassionate positively impacts and creates compassion for her staff, this isn't always the case, suggesting that perhaps there is more to compassion than whether we receive it or not. This sub-theme does, however; demonstrate the impact that compassion can have on developing and maintaining relationships with colleagues within a working environment. All participants described the impact that having compassionate colleagues

and ward managers can have on their job satisfaction and well-being and their ability to be compassionate to others and their patients. As West (2021) highlights, working in teams is vital for healthcare quality but there is also good evidence that supportive teams, with good team leadership, have significantly lower levels of stress than dysfunctional or pseudo teams in healthcare. Participants demonstrate this further within the next sub-theme when they consider aspects of compassion and forming relationships with their patients.

Subtheme 3: Genuine desire to care

Staff discussed the importance of developing and forming relationships with patients that they care for. Participants reflected on the impact that a lack of compassion can have on their ability to be compassionate towards their patients, as well as reflecting on their genuine desire to care for and do their best for their patients and how important and impactful compassion can be for the patients.

When participants were asked what the rewarding aspect of their job was, nearly all participants described forming or having a relationship with patients as the most rewarding aspect. Participants discussed the different ways in which they attempt to form a relationship or connection with their patients, given the nature of their diagnosis:

> "When you see them (patients) smile when you're interacting with them and they can have a conversation back with it because they remember something. When they say thank you." (Diane, Health care support worker, Ward)

> "I was just sat there for about 20 minutes holding his hand and it was just nice." (Simon, Health care support worker, Ward)

> "Seeing a smile on someone's face, and if they're able to give a bit of banter….they still got a twinkle in their eye… they have spirit in them." (Russo, Health care support worker, Ward)

> "I like sitting, talking to them [patients], reminiscing with them, sometimes it works, sometimes it doesn't. Uh, but there's always something you can take out of each individual patient." (Charlotte, Health care support worker, Ward)

The above data extracts demonstrate aspects of forming a relationship and connection with patients. These aspects are not too dissimilar from the aspects of compassion that were described by staff above when they were talking about what compassion from staff, ward managers and senior management looks like. The extracts from interviews with

Diane and Russo articulate the rewarding aspects of forming a relationship with their patients as when patients are able to reciprocate that connection in some way, either by interacting with the staff member in the form of a conversation or smile, or by demonstrating an understanding of the care by staff by saying thank you. These aspects of what staff felt were rewarding are similar to what staff spoke about wanting from their colleagues, ward manager and senior management when they were talking about receiving compassion. The data extracts from Simon and Charlotte's interviews demonstrate the rewarding aspects of compassion as not necessarily being a conversation, but having contact with or being present for the patient, which is again, what participants were discussing previously when thinking about aspects of compassion. Kitwood (2019) delineated a person-centred model of dementia care, contending that cultural values, the social and emotional history of individuals with dementia, and the daily caregiving practices might potentially influence the progression of the disease. Kitwood expresses a perspective on dementia that highlights the social construction of the condition and emphasises the significance of understanding the person with dementia as a foundational element for delivering high-quality, personalised, person-centred care. The term "socially constructed" implies that our understanding and interpretation of dementia are influenced by societal and cultural factors rather than being solely a biological or medical phenomenon. Kitwood's approach suggests moving beyond a purely medical model of care to one that recognises the individuality, experiences, and needs of the person with dementia. By acquiring knowledge about the person, including their preferences, history, and unique characteristics, caregivers and healthcare professionals can provide care that respects the individual's identity and enhances their well-being throughout the entire course of the condition. Person-centred care involves tailoring interventions and support to the specific needs and preferences of each individual, fostering a more dignified and respectful approach to dementia care. These data extracts highlight the everyday aspects of compassion that are evident in staff and patient relationships and emphasise the importance of compassion to harness person-centred care and relational care within dementia.

Healthcare workers felt that compassion was central to their job role and that compassion was required all of the time when caring for patients. Furthermore, they

discussed how compassion affects the ability to connect with and form a relationship with patients. This is demonstrated in the following data extracts where participants talk about the impact that compassion or a lack of compassion can have on their patients, and how this can also affect the effectiveness of interventions and the patients' progression whilst on the ward:

> "It's very important in this job to have that compassion, when you work as a team, then there's positivity and that helps the patient have a really good day and enjoy the day." (Diane, Health care support worker, Menyn ward)

> "I think we should all have compassion because you know, you need to give dignity and respect to these patients, well to everybody, so anyone that comes onto the ward really." (Sarah, Health care support worker, Ffion Ward)

These data extracts shed light on the multifaceted importance of compassion in healthcare, offering nuanced insights beyond a mere recognition of its significance. Diane, a Healthcare Support Worker, highlights the intrinsic value of compassion by emphasising its role in cultivating a positive team dynamic. Her perspective suggests that compassion not only contributes to a harmonious work environment but also directly influences patient well-being, fostering enjoyable and fulfilling days. Furthermore, the universality of compassion is highlighted by another participant (Sarah), who advocates for extending compassion to all individuals entering the ward, emphasising a broad culture of dignity and respect within healthcare settings. Both extracts subtly call for empathy in healthcare, as evidenced by Diane's mention of patients "enjoying the day" and Sarah's emphasis on providing dignity and respect, indicating an understanding of the emotional and psychological dimensions of patient care. Additionally, these reflections on compassion may signify a cultural shift in healthcare, moving beyond a purely task-oriented approach to embrace a more holistic understanding of patient well-being. Overall, these insights deepen our understanding of the pivotal role compassion plays in shaping team dynamics, patient experiences, and the evolving cultural expectations within the healthcare context. Further, Sarah comments on the importance of demonstrating compassion by having dignity and respect for "everyone." This suggests the role that compassion in healthcare can have as it acts as a unifying force, transcending societal divides by promoting cultural sensitivity, reducing health disparities, emphasising patient-centred care, building trust, fostering empathetic communication,

encouraging community engagement, and advocating for social justice. These elements collectively contribute to a healthcare environment that is more inclusive, equitable, and responsive to the diverse needs of society

Participants were asked what they felt the impact and significance that compassion can have on patient care and patient outcomes. Below are two further examples of the positive impact, which these participants felt that staff's compassion had on their patients:

> "You see so many success stories, you know, really as you've seen some of the guys, even with dementia, but mainly the functioning, come in and they were really high and psychotic and then over time they slowly come round and be a completely different person. Like and then, yeah, most of them acknowledge that as well and they thank you which is nice and perhaps not all much with the dementia patients because they aren't gonna get better, but we do mainly get them more calmer and happier." (Simon, Health care support worker, Ffion ward)

> "And the reaction of the families, when you show them, like sometimes you have photos of them doing stuff and they're like, "Oh, I didn't realise they were able to do that", you know. To see them progress and then maybe go home, that's fantastic, it's really good". (Sam, Health care support worker, ward)

Further, one staff member discussed the impact they felt the lack of compassion within the staffing team, and from the ward management had on the patients in their ward:

> "When it comes to like patients and stuff, I think the patients have suffered because of a result of just everyone's low, like low morale. I wanna say that the NHS at the moment can be quite unsafe. It's quite negative, really. (Katie, Nurse).

These data extracts demonstrate the impact that staff-felt compassion can have on their patients. Research supports the notion that when patients experience compassion, it fosters an environment where individuals perceive understanding and support from staff who actively demonstrate empathy, engage in active listening, and genuinely care (Menendez et al., 2015).

Summary of theme

The theme compassion is relational captures how participants discussed compassion and how it influences and shapes their connections with others within their workplace, the NHS, how compassion arises from an understanding of shared experiences and interconnectedness, and how its expression fosters empathy, support, and

understanding. When people demonstrate compassion, including among staffing groups, it strengthens interpersonal relationships, builds bridges across societal divides, enhances professional practice, and facilitates conflict resolution.

Participants highlighted and discussed feeling a lack of connection with and thus compassion from the health board as a whole and senior management. However, when hearing participants discuss their ward managers and colleagues, all participants highlight the key difference it can make if the ward manager demonstrates compassion to their staff. In the wards where participants have expressed positive views regarding compassion in the workplace, it is noteworthy that discussions about staff shortages, challenging working conditions, and personal life stressors persist, much like the ward where participants had negative reflections on their compassion experiences. As West (2021) posits, the experience of compassion from others, particularly from management within the workplace, significantly influences individuals' perceptions of themselves, their colleagues, and the overall organisational environment.

Compassion is Contextual

In exploring the factors influencing staff's ability to maintain compassion for both colleagues and patients, participants articulated a range of considerations, spanning environmental, cosmetic, spatial, and situational dimensions. They highlighted the significance of factors like ward ambience and the demands placed on the ward, including the quality and appearance of hospital buildings. Additionally, situational factors came to the forefront, with participants delving into the impact of patient diagnoses, particularly emphasising how conditions such as dementia could influence their levels of compassion. Other situational factors included the duration of a patient's stay on the ward and the pivotal moments when participants engaged in end-of-life pathways.

Drawing from these rich insights, three discernible subthemes emerged to encapsulate the nuanced nature of the discussions. 1) Compassion or efficiency, reflecting the tension between providing compassionate care and the efficiency demands of the healthcare setting; 2) The impact of the diagnosis, underscoring the profound influence of varied medical conditions on the staff's compassionate approach; and 3) Existential angst,

capturing the complex emotional and existential challenges that arise in the face of end-of-life care and prolonged patient stays.

Participants commonly labelled patients as either "dementia" or "functional" individuals, with functional describing those who do not have a diagnosis of dementia. Participants described how the wards use to maintain strict segregation, with some areas designated exclusively for patients diagnosed with dementia and others for those without the diagnosis. In response to the COVID-19 pandemic, the older person's mental health wards transformed, and at the time of data generation, wards were organised into distinct units: an assessment ward, a male ward, a female ward, and a mixed-gender dementia ward. Whilst, the terminology and use of the word 'functional' is no longer advocated within the health board, and wouldn't be considered to be a compassionate way to differentiate diagnosis, as a participant used this word throughout a quote stated below, it felt appropriate to provide some context for the reader.

Subtheme 1: Compassion or Efficiency

In exploring the diverse contexts within a complex mental health ward, participants engaged in insightful discussions regarding the intricate balance required to navigate multiple tasks, meet the needs of both patients and staff, and respond to the varied organisational demands that shape their ability to demonstrate compassion. Amidst these nuanced conversations, the emergence of a pivotal subtheme, titled "Compassion or Efficiency," highlights a central tension faced by healthcare professionals. After sharing examples of moments when participants had delivered compassionate care, they were then asked about the factors they believed enabled their compassionate care during those instances. Participants proceeded to articulate several key elements that they believed empowered them to provide compassionate care:

> "The time of day, which sounds really bad, but like it was the middle of the morning, so it was a night shift, so not many people around, you know, there are no distractions of all other patients there was, just, the time really." (Katie, Nurse, Eirys ward)

> "Well, unm, we were giving tasks and then I was delegated then to take over to make sure the patient had dignity within that situation." (Sarah, Health care support worker, Ffion ward)

> “The scenario, the situation and experience as well that you’ve got doing the job all the time. I think it just naturally comes upon you, I think experiences allow you to be able to deliver that.” (Nathan, Nurse, Ffion ward)

> “I think it’s just learning how to, you know, learning that patient and then we pass it on to other staff so everybody knows.” (Sam, Health care support worker, Ffion Ward)

These quotes offer a compelling glimpse into the intricate dynamics of balancing compassion and efficiency within the healthcare setting, providing nuanced insights into the subtheme of "compassion or efficiency." Katie and Sarah discussed how being delegated and given time as a member of staff to deliver compassionate care allowed her to focus, with no distraction on that patient and give them their full attention. Katie's consideration of the time of day during her night shift highlights the impact of temporal factors on the delivery of compassionate care, emphasising the delicate balance between time constraints and focused attention. Sarah's reflection on task delegation emphasises the challenge of preserving patient dignity within the realm of efficiency, illustrating the ongoing negotiation between task demands and compassionate practice. Nathan and Sam touched upon what other participants also spoke about, the amount of experience they have with that specific situation and the clinical and communication skills of the staffing team. Both Nathan and Sam reported that having sufficient knowledge and understanding of their patients and typical situations that may present themselves, as well as possessing adequate clinical and communication skills, enhanced their ability to be compassionate. Nathan introduces the concept of experiential wisdom, suggesting that accumulated experiences in the healthcare profession naturally contribute to the ability to deliver compassionate care, reinforcing the complex interplay between efficiency and the compassionate aspect of caregiving. Sam's emphasis on patient-centred learning highlights the importance of understanding individual needs as a foundation for both efficient and compassionate care. Collectively, these narratives weave a rich tapestry that elucidates the multifaceted nature of "compassion or efficiency" within the healthcare context, where healthcare professionals navigate the challenges of delivering meaningful care while managing the practical demands of their roles.

Participants also reflected on a time when they may have lacked compassion during their time working on the ward, following this, they were asked about what they believed caused them to lack compassion within that example:

> "Usually it's the busyness of the ward, that's what usually stops it [compassion]. All the paperwork that you have to do and all the bouncing between each patient, so like your mind is on one thing, so you got to put that on the shelf sometimes, say hello to this person, then grab it back, but sometimes that's easier said than done, you know what I mean?" (Ross, Student Nurse, Ward)
>
> "It's hard to stay so compassionate. Do you know when you're in so much stress and outside influences, I've noticed with staff as well, your gonna lose your empathy." (Sam, Health care support worker, Ffion ward)
>
> "Look at the conditions, so say the hospital that we are in now, it's not really great – it's quite run down, it looks a bit… dodgy." (Russo, Health care support worker, Menyn Ward)

These three data extracts are just some examples of the barriers that participants described that can affect their ability to be compassionate towards patients and colleagues. Participants, similar to Ross, discussed how juggling demands and the stress and pressures of these demands prevent them from acting compassionately. Judge et al. (2013) highlighted an efficiency discourse that is operationalised at the point of care that emphasises time pressures, care processes, and organisational tensions in a way that comprises best practices and contributes to the entrenchment of a production-line mentality. Sam demonstrates how factors originating outside of the ward along with the stresses within work can also cause them to lose their compassion in certain situations. Most participants spoke of paperwork demands, clinical staff meetings, meetings with family members of patients, challenging behaviours within dementia, staff tensions and differing work ethics, staff shortages and patients requiring observation all as being common challenges and issues that they often face whilst on the wards and that can impact their ability to be compassionate with patients. Russo discussed the conditions of the buildings and the staff facilities in the ward. Russo's data extract highlights the impact that the context and environment can have on a person's ability to be compassionate, research has also demonstrated that the more positive staff are about their working conditions, the more positive patients are about their care (West, 2021). The subtheme of "Compassion or Efficiency" encapsulates a poignant narrative within the healthcare landscape, shedding light on the intrinsic tension between the imperative for

compassionate care and the practical demands of efficiency. It serves as a lens through which healthcare professionals navigate the complex interplay of time constraints, task delegation, experiential wisdom, and patient-centred learning. These narratives reveal a perpetual negotiation between the desire to deliver meaningful, empathetic care and the necessity to meet the organisational demands for streamlined and efficient healthcare delivery. The opposition lies in the inherent challenge of reconciling the humanistic, individualised aspect of compassionate care with the broader efficiency goals of the healthcare system. This subtheme, therefore, stands as a compelling portrayal of the delicate equilibrium healthcare practitioners strive to maintain, embodying the ongoing struggle to harmonise the compassionate essence of healthcare with the pragmatic necessities of an efficient healthcare environment.

Subtheme 2: The Toll of Caring: Compassion Fatigue in Dementia and Mental Health

The narratives shared by healthcare professionals working in older persons' mental health inpatient wards illuminate the theme of "The Toll of Caring: Compassion Fatigue in Dementia and Mental Health." Participants expressed the complexities and challenges of providing care to individuals with dementia, detailing the emotional strain and difficulties in maintaining compassion. Compassion fatigue, also known as secondary traumatic stress, refers to the gradual decline in empathy and compassion experienced by caregivers due to prolonged exposure to the suffering of others. This condition is prevalent in professions such as healthcare and social work, where individuals routinely encounter emotional and traumatic situations. The key features include emotional exhaustion, reduced empathy, feelings of hopelessness, and changes in attitude, often accompanied by physical symptoms (Ledoux, 2015). The descriptions range from the profound sadness experienced when witnessing the impact of dementia on familial relationships to the frustration and guilt that arise when caring for patients with functional impairments. The differentiation in compassion levels across various diagnoses, as revealed in the participants' accounts, highlights the emotional toll of caregiving. The themes of confusion, aggressive behaviours, and the perceived lack of fulfilment in managing dementia contribute to a sense of weariness and emotional exhaustion. The experiences shared align with the concept of compassion fatigue, shedding light on how repeated, demanding interactions with dementia patients can

erode empathy, leaving caregivers grappling with the toll of caring for those with dementia.

Upon discussing the complexities and difficulties of working in an older person's mental health inpatient ward, participants spoke of the nature of the diagnosis of dementia and the challenges that can often come with this diagnosis. Further, participants spoke of the difficulties of having both patients with a dementia diagnosis on the wards with those who did not have a diagnosis of dementia but were admitted with severe and complex mental health issues. Participants discussed the different ways that the patients and their diagnosis might affect their ability to be compassionate. Some participants acknowledged a difference in how they view the compassion that they have for differing diagnoses:

> "Yeah, because you got a lot of time for dementia. You may not have a lot of time for functional because you are more with the dementia patients than the functional. Which is even worse, because you want to be more compassionate for them because you know, they want somebody to talk too, and if they are feeling down, which they are in here for, could be depression, suicide, you know, you want the time to sit and chat to them." (Sarah, Health care support worker, Ffion ward).

> "There have been times where one of our functional patients has been quite incontinent and I've just been like "oh, for God's sake", you know, 'cause she understands and stuff and I'm like you know, "you knew you needed to go to the toilet, why didn't you just go". And then, afterwards, you feel really guilty, and I did go up to her and I said "I'm really sorry"." (Katie, Nurse, Eirys ward)

The above statements by both Sarah and Katie demonstrate how compassion differs across diagnoses. Sarah describes a need to have more compassion for patients living without a diagnosis of dementia whilst acknowledging the difficulty of doing this in reality due to time pressures and challenges with those living with dementia. Katie discusses the difference in expectations towards various diagnoses based on the perceived level of understanding that patients have and how staff, such as herself may lose their compassion slightly easier with patients that are perceived to have more understanding, such as those living without a diagnosis of dementia.

Further, participants discussed the challenges and difficulties of working with patients who are living with dementia. The following data extracts followed discussions around how participants felt that working within older persons' mental health inpatient wards may impact their ability to maintain compassion throughout their career:

> "It's hard work, can be sad, especially with dementia, it's just, seeing the family can be hard, to see that, how the family member has become, they don't recognise them, and that is, yeah that is sad." (Russo, Health care support worker, Menyn ward)

> "Yeah, the confusion, and that they don't understand, even if you're offering to help, but it's how to deal with that. So you know, there's quite a lot of skill to learn how to deal with the different situations." (Sam, Health care support worker, Ffion ward)

> "They're aggressive, which isn't their fault, but it can be hard to deal with, you know, they're elderly, they're frail but they're also aggressive and they're also you know, being physically towards you. So I definitely think older adults and dementia is quite challenging." (Katie, Nurse, Eirys Ward)

> "We don't cure, we just help manage it a little bit better, it's never an actual cure, it's more of a managing, being able to manage their needs better. So it's not always a rewarding and fulfilling job, I found that whilst here, umm, we do however, we do have some patients that come in that are acutely unwell, not linked to dementia and when we treat them, they get better and obviously that is a more rewarding side." (Nathan, Nurse, Ffion Ward)

There are four different aspects described by these four participants regarding factors that may impact their ability to maintain their compassion. Russo discusses an overall sense of sadness towards the nature of people living with dementia being unable to recognise their family members – a sadness regarding the observation of a lack of connection and remembered relationship with their loved ones, which the participant recognises can act as a barrier to their compassion. Sam discusses the confusion and lack of understanding that some patients living with dementia may have towards staff, a lack of understanding and thus, connection with staff, and not being aware that staff may try to help them. Katie spoke about the challenging behaviours that may present with a dementia diagnosis, particularly physical aggression and how this can affect their ability to remain compassionate towards patients. This is supported by research such as Bickford et al. (2019) who found that student nurses believed that perceiving people with dementia as violent, aggressive, frustrated, or distressed could diminish their compassion. Finally, Nathan's response has a sense of hopelessness, which is captured in his comparison with other aspects of nursing where they may look to cure or treat someone of their illness, but his role is to manage dementia a little bit better. As Nathan discussed in the context of his compassion and its ebbs and flows during his career, this factor plays a role in diminishing his compassion. The aforementioned quotations seem to align with

the concept of compassion fatigue, which can occur when caregivers engage in repeated interactions that demand a high level of empathetic engagement with distressed clients (Figley, 2002). Further, Sorenson et al., (2016) found that compassion fatigue often included a range of symptoms, including a decreased ability to feel empathy and a lack of meaning in work.

In conclusion, "The Toll of Caring: Compassion Fatigue in Dementia and Mental Health" delves into the intricate challenges faced by healthcare professionals in older persons' mental health inpatient wards. The narratives provided by participants illuminate the emotional strain of caring for individuals with dementia, highlighting the nuanced nature of compassion fatigue. From the profound sadness of witnessing the impact on familial relationships to the frustration and guilt associated with functional impairments, the theme highlights the multifaceted toll of caregiving. Differentiation in compassion levels across various diagnoses, coupled with the themes of confusion, aggressive behaviours, and the perceived lack of fulfilment in managing dementia, collectively contribute to a sense of weariness.

Subtheme 3: Existential Angst

The topic of death surfaced prominently in discussions among nearly every participant, serving as a focal point when they reflected on factors influencing their capacity for compassion. Navigating the complexities of nursing care for older individuals on an end-of-life pathway involves not only addressing the physical aspects of their condition but also delving into the intricate realm of subconscious existential angst. The unspoken fears, uncertainties, and reflections on life's meaning can influence not only the emotional well-being of the individuals receiving care but also the approach and responsiveness of nurses. Participants consistently emphasised that providing compassionate care reached its pinnacle when attending to individuals on an end-of-life pathway or those who had already passed away:

> "My last patient passed away. So like, it's just being compassionate by like, holding their hand while there, you know, it's dignity in dying, making sure their comfortable, providing emotional support. From the time when he was passing away to the time when he'd gone, you know. Yeah, that would be the time I delivered compassion, the last time, where I can truly say that was, you know, I gave it my all." (Katie, Nurse, Eirys ward)

> "We've had patients that are acutely unwell, that might be on a pathway, end of life and syringe driver you know, you got to be very compassionate with them, spending time with him, reassuring him, making sure he was comfortable." (Nathan, Nurse, Ffion ward)

> "When a patient passed away. And obviously, you um, did all the right procedures; you know, made them dressed, clean and presentable for the families to come in so I think that was one of the best." (Sarah, Health care support worker, Ffion ward)

Across all three quotations, there is a common narrative, that when participants were asked to think about compassionate care and to give an example of when they delivered compassionate care all three participants (and nearly every other participant) thought of a time when a patient had passed away. Whilst talking through their examples, all three felt it was the "best care" (Sarah), or they had to be "very compassionate" (Nathan), or they "gave it their all" (Katie). The language used here implies that participants perceive compassion as having different levels, where one can 'increase' the amount of compassion or effort dedicated to providing it. Notably, participants consistently associated their highest 'level' of compassion with end-of-life moments and the aftermath of a patient's death. Relevant studies support these observations by exploring nurses' attitudes toward caring for dying patients and revealing that personal attitudes toward death can significantly impact nurses' emotional responses and overall attitudes (Braun, Gordon, and Uziely, 2010; Novak et al., 2010; Sorensen and Iedema, 2009; Tay et al., 2014). These findings align with the participants' emphasis on end-of-life scenarios as pivotal moments for the manifestation of heightened compassion in their care practices. Graham et al. (2005) suggested that caring for a dying patient not only involves facing the distress of others but also evokes personal memories of losing family members. A study by Huang et al. (2016) found that nurses often experience healing through caring for patients or dealing with their own unfinished business and through participating in the funeral and memorial services of patients.

Interestingly, when participants were questioned about the factors that facilitated their compassionate care in the data extracts above, they predominantly provided contextual reasons, including considerations such as time, experience in the situation, and the learning process. Despite all participants recounting instances of compassionate care related to a patient's death, none delved deeper into the broader topic of death itself.

This observation raises the possibility that participants might not have consciously recognised death as a factor enabling their compassion. It is conceivable that, instead, they associated or acknowledged the situational and contextual factors that unfolded after the patient's death. While the emotional and subconscious impact of death may have resonated with them, the focus in their discussions appeared to centre on the specific circumstances and events that followed the passing of the patient. It could be suggested that the act of caring for someone who is passing away initiates unconscious existential angst and that as a way to manage this, careers "go above and beyond" and "do all they can" to care. This idea finds support in studies that have explored existential distress among healthcare providers caring for end-of-life patients. In a study conducted by Breen et al. (2014), 38 oncology healthcare professionals were interviewed, revealing numerous emotional challenges, including the need to come to terms with their own mortality. Likewise, palliative medicine specialists have described how their work continually serves as a reminder of their own mortality (Zambrano, Chur-Hansen, and Crawford, 2014). Pessin (2015) emphasises the distinctions between staff who frequently encounter death and those who do not. Within OPMH inpatient services, staff might not have previously encountered death as frequently as they did during the COVID-19 pandemic, which saw a high number of patient deaths. Existential angst refers to a deep-seated sense of unease, anxiety, or dread that arises from contemplating one's existence, purpose, and the nature of life. It is rooted in existential philosophy, which explores fundamental questions about human existence, freedom, choice, and the search for meaning. Existential angst often emerges when individuals confront the uncertainties and complexities of life, grapple with their mortality, or question the significance of their actions and experiences. The experience of existential angst among patients facing the end of life within the NHS is a profound motivator for enhancing compassionate care. Research suggests that individuals when confronted with their mortality, may project a fear of dying onto their healthcare providers. This projection intensifies the significance of compassionate care, as patients seek solace and understanding in the face of existential uncertainties (Ashby, 2017). Moreover, healthcare professionals, tasked with caring for those nearing the end of life, often grapple with their existential concerns, experiencing the pressure of providing comfort and support during such critical moments. Studies, as

demonstrated by Virdun et al., (2015) have illuminated the reciprocal relationship between the fear of dying and the pressing need for heightened compassion in healthcare settings. Acknowledging and addressing existential angst not only contributes to a more empathetic patient-provider dynamic but also highlights the imperative for comprehensive training and support systems within the NHS to foster a culture of compassion and resilience among healthcare professionals.

Summary

The theme of compassion within the context of participant discussions extends beyond relational aspects, covering factors pertinent to the intricacies of dementia care and the challenges inherent in an inpatient setting. Participants detailed how the complexities of their work, particularly within dementia care, and the dynamics of an inpatient environment can sometimes erode their sense of compassion. The nature of the dementia diagnosis emerged as a significant factor influencing their ability to be compassionate, alongside the recognition of the ongoing relevance of compassion, especially when patients transition into an end-of-life pathway. Sub-themes and participant narratives highlight aspects of their work that participants believe warrant greater understanding from managers, senior leadership, the organisation, and society at large. A notable sentiment among participants is the perception of managing these challenges without sufficient support or appreciation, contributing to a potential decrease in compassion. These discussions provided an avenue for staff to articulate the difficulties they encounter in their careers, shedding light on factors that may lead to compassion fatigue, burnout, and a decline in overall job satisfaction.

Compassion is Personal

The concluding theme, "Compassion is Personal," captures diverse dimensions of compassion explored by participants in their interviews. These individuals conveyed compassion as a fusion of personal values, emotions, and life experiences. While some acknowledged external influences, such as upbringing and past encounters, others conceptualised compassion as an intrinsic quality uniquely expressed through their thoughts, feelings, and actions. Three subthemes enrich this overarching theme: 1) Wounded Healing; 2) Personal Reflection; and 3) “It’s just who I am, it’s innate.”

Subtheme 1: Wounded Healing

Participants reflected on their encounters with pain, loss, or adversity and how this can deepen their understanding of human suffering and foster a heightened sense of empathy. These experiences offer a personal perspective through which individuals channel compassion, enabling them to connect on a deeper level with others who are facing similar difficulties:

> "My mother suffered a stroke about six years ago as well, losing her voice, but she's got it back, so these little things, I think, add up to the character, that you build and you are able to be." (Ross, Student Nurse, Menyn)

> "I try to see from their point of view, that's very important for me because when I've been in hospital myself, I wanted to be treated like a human being with dignity and respect, so it's very important." (Diane, Health care support worker, Menyn Ward)

> "I think because of my experiences of fear during ill health, and a lot of our patients are older adults, so they are more vulnerable than what I was, that's allowed me to be a lot more compassionate towards them." (Nathan, Nurse, Ffion ward)

The reflections shared by Ross, Diane, and Nathan resonate strongly with the concept of the wounded healer. Ross's transformative journey of caring for his mother following her stroke not only shaped him personally but also became a source of strength that informs his compassionate nature. Similarly, Diane's recounting of her own hospital experience, marked by intense emotions and a desire for specific treatment, serves as a touchstone for her empathy towards patients. Nathan's struggles with his own health concerns have uniquely positioned him to understand and connect with the challenges faced by patients. In each case, it is through these personal wounds that these individuals have developed a profound capacity for compassion, aligning with the archetype of the wounded healer in the healthcare profession which has been demonstrated whenever there are caregivers who are themselves 'damaged' but learn to use their suffering to help others (Conti-O'Hare, 2002; Heinrich, 1992).

Much has been written in psychology about the wounded healer and how the healer's own wounds become instrumental in the healing process (Rice, 2011; Hadjiosif, 2021; Martin, 2010). Miller et al., (1998) described the power of the wound as being instrumental in its ability to foster empathy, understanding and acceptance in the healer.

The term "wounded healer" was popularised in modern psychology by the Swiss psychiatrist Carl Jung (1951). Jung introduced the concept as part of his analytical psychology framework. He believed that individuals who undergo personal struggles, crises, or psychological wounds can develop a deeper understanding of human suffering and, as a result, become more effective in helping others heal. The wounded healer concept is not limited to psychology but has also found resonance in various fields, including healthcare. In the context of nursing care and healthcare professionals, it suggests that those who have experienced personal challenges or adversity may bring a unique level of empathy and understanding to their roles, potentially enhancing their ability to connect with and care for patients. This is demonstrated in a study, which included interviews and focus groups with 54 nurses that examined this concept with nurses who have contracted the COVID-19 virus. The main findings were that the nurses who contracted COVID-19 became “wounded healers”: they survived and recovered, but remained “wounded” by the experience, and returned to caring for patients as “healers,” with increased compassion and attention to basic needs. Through this life-changing experience, they strengthened their ability to build therapeutic relationships with patients and re-discovered fundamental values of nursing. These are some of how nurses can express most profoundly the ethics of work done well (Piredda et al., 2022).

The concept of the wounded healer highlights the idea that individuals who have personally experienced adversity or challenges can develop a deeper sense of empathy and compassion (Lim and DeSteno, 2016). In the context of healthcare, including nursing care, this heightened empathy can translate into more compassionate and understanding patient care (Leana, Meuris and Lamberton. 2018). By intertwining their personal narratives with their professional roles, participants embodied the essence of compassionate care, demonstrating that genuine understanding and empathy, born out of personal wounds, contribute significantly to the delivery of heartfelt and empathetic healthcare. This is demonstrated in Stone's (2008) article which intricately weaves together Eastern philosophical perspectives, alternative healing modalities, and contemporary Western psychological research to illuminate the profound nature of healing compassion. Grounded in the concept of the wounded healer, the article explores how personal wounds and challenges serve as the catalyst for the emergence of

compassion within healers. This healing compassion, rooted in the healer's own experiences, extends outward in a transformative cycle. The cyclical process outlined by Stone reflects the interconnected nature of compassion, as it flows from the healer's own wounds to the recipient and then returns to the healer in a circle of healing energy. This intricate dance between the healer's personal struggles, the act of extending compassion to others, and the reciprocal return of healing energy encapsulates the essence of the wounded healer archetype and highlights the vital role of personal experience in fostering genuine compassion within healing practices.

Subtheme 2: The Compassionate Self: Mindfulness, Empathy, and Self-Reflection

The sub-theme 'The Compassionate Self: Mindfulness, Empathy, and Self-Reflection' delves into the profound interplay of personal attributes that contribute to compassionate care among healthcare professionals. Some participants explained compassion as something that stems from different practices that they engage with, or that it stems from learning and seeing compassion within the family when growing up:

> "I don't know, just, my upbringing, I came from a big family and it's the way of being brought up, making time for others. I think I probably got compassion from there." (Chloe, Ward manager, Ffion ward)

> "On a whole, definitely spirituality, definitely, I've explored that for ten years and remained in that creation. And so, it, [compassion] can be practised, and experience and knowledge and through other means as well, for me, mostly mindfulness meditation and exercising and stuff like that, that's what I use personally." (Ross, Student Nurse, Menyn ward)

> "For me, I'm an empath, I pick up on people's emotions. I think it stems from my own self-compassion. I often self-reflect and practice mindfulness and self-compassion which helps me when being compassionate towards others." (Hannah, Nurse, Lili Ward)

These participants discussed the different ways in which they felt that their compassion was developed and how it can be maintained throughout their careers. Chloe comprehends compassion as devoting time to others, and she believes that her family instilled this value in her from a young age. As a result, she believes that she cultivated her compassion from a young age, and these personal experiences of compassion continue to drive her to make time for others in both her personal and professional life. Participants, like Ross and Hannah, shed light on the role of mindfulness in cultivating their compassionate approach. Ross mentions engaging in mindfulness meditation and

exercise, aligning with research by Neff and Pommier (2013), which highlights the positive correlation between mindfulness practices and the extension of compassion to others. Furthermore, the theme emphasises the significance of self-reflection, echoing Neff's (2003) components of self-compassion. This resonates with research showing how self-compassion, nurtured through mindfulness and self-reflection, is a key factor in boosting healthcare professionals' capacity to deliver compassionate care. The delicate interplay among mindfulness, self-reflection, and compassion, evident in personal stories shared by participants and scholarly literature, highlights the intricate dimensions of cultivating a compassionate self within healthcare environments. Moreover, studies by Neff (2003) delve into the components of self-compassion, identifying mindfulness as a key element. The participants' engagement with mindfulness practices, such as meditation and exercise, aligns with Neff's framework, emphasising the role of being present and aware in fostering compassion. This connection between mindfulness and self-compassion becomes a crucial foundation for extending compassion to others, as indicated by the participants' narratives. Additionally, the theme highlights the importance of self-reflection in nurturing the compassionate self. This resonates with broader psychological literature that recognises self-reflection as a means to deepen understanding and empathy. As healthcare professionals embark on a journey of self-reflection and mindfulness, they not only enhance their personal well-being but also strengthens their capacity to provide compassionate and empathetic care to those they care for. The insights shared by fellow practitioners with established research highlight the Reciprocal relationship between self-compassion, mindfulness, self-reflection, and the delivery of compassionate care within healthcare contexts.

Subtheme 3: It's just who I am, it's innate

In contrast to the above two sub-themes, some participants felt that compassion was something that was innate, that a person is either born with compassion and thus can develop or lose this compassion through different factors, or that a person would be born without compassion and that those people are unable to learn compassion:

> "I do think you've got to be born with compassion. I don't even know whether you could learn it. I'm not too sure because I'm not sure you can teach someone to be compassionate. I think, like, even if you train someone to be compassionate and they just are not compassionate, it would almost be like they are just lying in

doing so. I don't know really. I don't know whether it would work." (Katie, Nurse, Eirys ward)

"I think I was quite compassionate when I started. Yeah, I think it's in you, either you aren't or you are, personally." (Simon, Health care support worker, Ffion ward)

"I think to be honest, you have to be a compassionate person, you have to be a compassionate person without even stepping on the wards. I think compassion is something that is innate, that you've either got it or you haven't, so I don't think you can learn compassion." (Diane, Health care support worker, Menyn ward)

The quotes from Katie, Simon, and Diane illuminate distinct perspectives on compassionate care within healthcare. Katie's viewpoint challenges the notion that compassion can be taught, emphasising a belief in its innate nature. She raises scepticism about the authenticity of trained compassion, suggesting that attempting to teach someone inherently uncompassionate may result in insincerity. Simon's reflection aligns with the idea that compassion is an inherent trait, implying that individuals possess it intrinsically, and it is not a skill to be acquired. Diane echoes this sentiment, emphasising that compassion is something individuals must possess even before entering the healthcare profession. Collectively, these perspectives suggest a shared belief among healthcare professionals in the intrinsic nature of compassion, challenging traditional notions that it can be entirely learned. These viewpoints carry implications for training programs and recruitment strategies in healthcare, advocating for the recognition and prioritisation of individuals with an inherent capacity for compassion. The doubt surrounding the teachability of compassion raises questions about the effectiveness of training interventions alone in fostering genuine and authentic compassionate care. This collective perspective emphasises the importance of recruiting individuals who already embody compassionate qualities, suggesting that the authenticity of compassionate care may be rooted in an individual's innate disposition rather than solely learned behaviours. The notion of compassion being innate has been a topic of discussion in both psychological and philosophical literature. One line of research that supports the concept of innate compassion comes from studies in developmental psychology. Researchers like Martin Hoffman (1990), for example, have explored the early emergence of empathetic responses in infants, suggesting that a rudimentary form of empathy is present from a very young age. This supports the idea that the capacity for compassion may have

evolutionary roots, aiding in the formation and maintenance of social bonds. Philosopher and psychologist Rousseau (2004), in his work on natural human goodness, proposed the idea that humans are born with a natural inclination toward empathy and compassion. Rousseau believed that societal influences could corrupt this inherent goodness, but the core capacity for compassion was present from the beginning. While the literature provides support for the idea of innate compassion, it's essential to note that this perspective is not without its critics. Some argue that compassion is a complex interplay of both innate predispositions and environmental influences (Gilbert 2007). The interaction between genetics and environmental factors, often referred to as gene-environment interplay, is a key consideration in understanding the development of compassionate traits. These insights contribute to ongoing discussions about the role of intrinsic compassion in healthcare practices and prompt considerations for refining approaches to training and cultivating compassionate healthcare professionals.

Summary

The theme compassion is personal captures aspects of what compassion means to participants, where it originates, how they identify with the concept and the impact this may have on how they view compassion in others and how they view initiatives surrounding compassionate leadership within the NHS. Concepts such as the wounded healer highlight the impact that personal experience can have on a person what may lead to a person entering a carer role and how these experiences may affect their compassion towards certain diagnoses, patients, staff and other's experiences. Further, it acknowledges the role that self-awareness and self-compassion can have on staff's ability to manage and overcome adversity and how this may benefit their ability to maintain compassion towards others. Finally, it acknowledges that some individuals perceive compassion as an innate quality that cannot be taught, viewing it as something that should stem from a sincere, deeply ingrained desire to care for and assist others.

Discussion

The analysis of participants' interviews on compassion provides insights into this concept's nuanced and everyday dimensions. Traditionally viewed as a behavioural response stemming from an awareness of others' suffering, compassion is often associated with a desire to alleviate that suffering. However, participants in this study emphasised the importance of feeling understood, having someone take the time to listen, and providing emotional support as integral components of compassion during difficult situations. This perspective is reinforced by those who experience compassion from their ward manager, showcasing the positive impact on their work experiences despite acknowledging its challenges.

The analysis also highlights the role of self-compassion and self-reflection in maintaining compassion among staff members. Three distinct aspects of compassion emerge: the relational aspect, fostering positive connections with colleagues, staff, and patients; the contextual aspect, assisting during challenging experiences and overcoming barriers; and the personal side, emphasising the importance of self-reflection and awareness in navigating difficult emotions and experiences.

In summary, this research unveils the nuanced and everyday facets of compassion. The subsequent section will provide a condensed overview of the analysis before revisiting the research questions to discuss the analysis of the research questions. The implications for counselling psychology, study reflections and evaluation, and potential future research needs will be discussed. The final section of the thesis offers a closing summary, emphasising the existence of three interconnected facets of compassion—relational, personal, and contextual—and their collective influence on individuals' capacity to extend compassion to themselves and others, particularly within the healthcare context. This study highlights the intricate nature of compassion, the absence of unanimous consensus on its definition, and the potential for effective expression through simple gestures.

Research Question 1

How do nurses and healthcare support workers working in OPMH inpatient wards within SBUHB understand and make sense of compassion?

This study found two main aspects of compassion: relational and personal. Furthermore, these aspects of compassion (and thus compassion itself) can be affected within health care by contextual factors. Throughout each interview and across all participants, the most common theme and aspect of compassion that was discussed was its relational underpinnings. All conversations around compassion spoke of seeking a connection, understanding, and feeling supported by another person. Participants spoke of how compassion can be crucial in establishing patient connections. This is consistent with research on patients' perspectives on and experiences of compassion, which has found that patients described feeling compassion when they have felt known by nurses and when nurses spend time with them despite the appearance that they did not have the time to give (Dewar and Nolan, 2013).

Similarly, Khan (1998) claimed that compassion had been found to result in caregivers being more likely to establish a connection with their patients, and both Broody (1992) and Cassell (2002) found that caregivers also provide more holistic care that treats the whole person rather than just the illness. Participants also spoke of how feeling connected with staff and having a relationship with their colleagues led them to reflect positively about compassion within the workplace. This view is also supported by research such as Frost et al.'s (2000) study, which found that compassion at work connects co-workers psychologically and strengthens their bond. Outside of healthcare and in organisations more broadly, Lilius et al. (2008, 2011) demonstrated that those who experience compassionate leadership at work are more likely to report affective commitment to their organisation and talk about it positively. They further state that compassionate leadership and experiencing compassion at work strengthen the relationship between employees, which reduces employee turnover and increases organisational citizenship.

The relational aspect of compassion was also present throughout the other themes, such as the second theme, compassion is contextual. Within this theme, participants spoke of how factors such as how the diagnosis of dementia is perceived can act as a barrier to forming relationships and, as such, can result in a lack of compassion. This can further be discussed and understood with reference to Kitwood's emphasis on making an emotional leap into the world of a person with dementia aligns with the evolving perspectives in dementia studies, as reflected in the work of Keady et al. (2022). Kitwood's approach recognises the importance of understanding and empathising with the emotional experiences of individuals with dementia, encouraging a more person-centred care paradigm. Similarly, Keady et al.'s conceptual framework challenges and expands the conventional notion of "being in the moment" within the dementia care continuum. Their work emphasises the need to re-think and re-position the concept, acknowledging that individuals with dementia experience a continuum of moments rather than discrete, isolated instances.

This evolution in understanding resonates with Kitwood's call for an emotional leap, as it recognises the dynamic and ongoing nature of the emotional experiences of individuals with dementia. Both perspectives advocate for a more holistic and empathetic approach to dementia care, emphasising the importance of engaging with the emotional realities of individuals living with dementia within the broader context of their experiences. This linkage highlights the continuous evolution in dementia care theories towards a more nuanced and empathetic understanding of the lived experiences of individuals with dementia. In addition, when participants spoke of compassion, they spoke of factors such as knowing their patients, having time to spend with them, and reassuring and talking with patients, all of which demonstrated their compassion.

This relational conceptualisation of compassion supports a study conducted by Sinclair et al. (2016), which explored how patients perceive and encounter compassion in healthcare. In this study, the defining aspect of compassion was the intent and depth of the healthcare provider-patient relationship. It extended beyond merely recognising and understanding the patient's needs to encompass relating to them as complete human

beings and actively engaging with and understanding their suffering. This also further suggests that compassion is more than attending to or understanding the needs of others but that it is relationally engaging and interpersonal interaction with another person. From a social psychology perspective, the importance and effect of reciprocity on relationships have been studied in great detail (e.g., Gang and Stukas 2015; Buunk and Schaufeli 1999). Buunk and Schaufeli (1999) highlighted those relationships between friends, marital partners, family and social situations are often based on reciprocity and that we cognitively assess the likeliness of receiving something back for our efforts within that relationship. These researchers assessed the impact of perceived reciprocity on caregiver-client relationships. They found and suggested that relationships such as these that are emotionally demanding and continue to be due to a lack of reciprocity may lead to professional burnout. They discussed "emotional exhaustion" (the depletion of emotional resources that result from working with "difficult" people), depersonalisation (psychological withdrawal and forming negative, cynical attitudes towards recipients) and "reduced personal accomplishments at work" (page 277). This interesting perspective on the underpinnings of relationships provides insight into some factors that may lead to a staff member 'losing' their compassion over their career. A lack of reciprocity from patients, colleagues and staff may affect their relationships with patients, colleagues and the organisation as a whole, especially if the lack of reciprocity extends to their organisation and colleagues. How people living with a diagnosis of dementia are viewed with regard to their ability to establish connections and relationships with others links with research regarding the impact of interpersonal positioning on older individuals, particularly those diagnosed with dementia. Research by Sabat (2008) highlights how older individuals position themselves reflexively and are positioned interactively by both younger and older individuals. Negative positioning, often arising from cognitive deficits associated with dementia, can escalate to malignant positioning, especially when premature assumptions lead to depersonalising treatment. This malignancy poses a threat to the personhood and self-worth of those diagnosed. Considering the anticipated rise in diagnoses of dementia, the study highlights the urgency of exploring the effects of such positioning. The projected increase in diagnoses, with implications for both direct and indirect stakeholders, emphasises the need for a comprehensive understanding of

the well-being of those diagnosed and the substantial financial costs associated with their care. In the context of my thesis, which explores compassion within healthcare settings, understanding the nuanced impact of positioning on individuals with dementia is crucial. It adds a layer of complexity to the relational and contextual aspects of compassion, providing valuable insights for healthcare professionals, particularly counselling psychologists, in fostering compassionate care within the ageing population (Sabat 2008)

The second aspect of compassion developed from the data is the personal factors, which include the person's individual differences such as spirituality, culture, values, experiences and beliefs, and self-compassion. As discussed throughout the analysis, the theme of compassion is personal and includes factors such as the wounded healer (Jung, 1951). Bennet (1979) stated, "The power of the wound lies in its ability to foster empathy, understanding, and acceptance in the healer" (page 4). This quote asserts that the potency of a wound lies in its capacity to bring about transformation in the healer. It suggests that wounds, whether physical or metaphorical, can cultivate empathy and understanding in those who undertake the role of healers. The experience of overcoming a wound is seen as a catalyst for fostering a deeper connection with the pain and challenges of others.

Moreover, the quote implies that this transformative process leads to heightened self-acceptance in the healer as they come to terms with their vulnerabilities and imperfections through the healing journey. The quote emphasises the profound impact of personal struggles on the healer's ability to relate, understand, and assist others in their healing journey. Stone (2008) described the process of compassion as arising out of the healer's wounds, flowing to the other and then returning to the helper in a circle of healing energy. The second factor discussed within the personal aspect of compassion was personal practises such as spirituality and mindfulness. Some participants felt that engaging in these practices made them more compassionate. Finally, some participants believed that compassion was inherent in their biology and constituted a core part of their identity, something innate that could not be taught.

This study, therefore, highlights two broad aspects of compassion for participants. As discussed below, the relational and personal aspects suggest that initiatives, training, and conversations about compassion should prioritise the significance of establishing secure and safe relationships with others while promoting self-awareness and self-compassion. This approach better equips individuals to extend compassion to others.

Research Question 2

What is their personal and professional experience of compassion within the health board and over their career?

The third theme explores the contextual aspects of compassion. The participants reported that these factors influenced their capacity for compassion in their work. One key factor was the prevalence of an efficiency-focused discourse within the NHS, encompassing organisational demands. There were diverse perspectives among staff when reflecting on their ability to provide compassion to patients and sustain this compassion throughout their careers. All four wards encountered challenges related to understaffing, with the cause not being a shortage of recruitment but the constraints imposed by management's adherence to budgetary limitations. This situation often led to an overcrowded patient-to-staff ratio, particularly challenging in dementia care scenarios, where patients frequently require 1:1 staffing. In addition, staff mentioned the burden of paperwork and non-clinical care demands they had to fulfil. Despite these challenges, two out of the four wards reported positive experiences of compassion, primarily attributed to the compassionate support they received from their ward managers. In contrast, those lacking a compassionate manager noted the negative impact on their compassion and, consequently, their relationships with colleagues and patients.

This organisational strain and the associated challenges resonate with the concept of moral injury in healthcare settings. Characterised by the internal conflict arising from the awareness that one can do better contrasted with organisational constraints preventing such improvements, moral injury poses a profound challenge. The tension, rooted in the desire for higher ethical standards and the knowledge that improvements are possible,

can lead to moral distress among healthcare providers. Haslam-Larmer et al.'s (2023) study delve into the prevalence, causes, and consequences of moral distress, specifically in healthcare providers caring for people living with dementia in long-term care during a pandemic, shedding light on the unique circumstances that intensify moral distress. Additionally, Rowlands (2021) contributes to the discourse by focusing on understanding and mitigating moral injury in nurses. This study explores strategies to address moral injury, offering practical insights into how healthcare organisations can support and empower their staff to navigate the tensions between their desire for improved care and the constraints of the organisational environment. Together, these studies not only underline the challenges faced by healthcare professionals in providing compassionate care but also advocate for organisational reforms to align with the ethical aspirations of healthcare professionals, a sentiment particularly crucial when caring for vulnerable populations such as those with dementia.

Within this theme, several other factors played a role in influencing participants' capacity for compassion in their work. One significant factor was the nature of the patient's diagnosis, as the specific conditions and illnesses patients were dealing with could substantially impact the emotional demands placed on healthcare providers. Additionally, emotionally challenging situations, such as the death of a patient, presented a profound test of compassion as healthcare providers navigated the complex emotions and responses that arise in such circumstances. The profound impact of caring for older individuals, especially those with dementia, is illuminated by the existential nature of this responsibility. The awareness of one's mortality and the potential future self in the position of the cared-for individual can trigger a range of defensive strategies among caregivers. As explored by Piiparinen and Whitlatch (2011), this existential loss becomes a crucial determinant of well-being in the dementia caregiving dyad. The conceptual model presented in their study delves into the complexities of existential loss and its implications on the overall well-being of both the caregiver and the person receiving care. Furthermore, McKenzie et al. (2017) contribute to this discourse by examining death anxiety and coping strategies among health professionals providing dementia care. The study sheds light on how the fear of mortality influences the well-being of health

professionals engaged in dementia care. It highlights the coping strategies employed by these professionals to manage the emotional challenges associated with caring for individuals with dementia. The findings highlight the psychological toll of caregiving and emphasise the need to understand and address the existential aspects that shape caregivers' experiences. Together, these studies provide valuable insights into the intricate dynamics of dementia caregiving, delving into the existential aspects that impact caregivers' well-being. Understanding these dimensions is crucial for developing comprehensive support strategies for caregivers and enhancing the overall quality of dementia care. These factors highlighted the multifaceted nature of compassion in healthcare and the dynamic interplay between individual characteristics, patient factors, and the broader organisational context.

Lastly, as previously mentioned, as an integral dimension of compassion, personal factors were examined concerning how participants perceive them to influence and affect their ability to sustain their compassion in the workplace. Those who demonstrated self-awareness regarding their struggles and personal "wounds" (as mentioned earlier) discussed how this self-awareness enhanced their capacity for empathy and compassion toward others. Additionally, participants highlighted the value of utilising the staff well-being service for debriefing, which provided a means to address the emotional toll of their work. Some also emphasised the significance of debriefing with supportive colleagues who offered assistance when needed.

Therefore, this study has highlighted the importance of staff receiving compassion from colleagues and ward managers and the positive impact this can have, even if they do not feel compassion from their senior management or the health board. It also provides insight into what may be helpful for staff working within these services to help them maintain their compassion throughout their careers.

Implications for practitioners

This study illustrates one way of viewing compassion and aiding staff within the NHS to become more compassion-aware and aid them in maintaining compassion throughout their career. The present study's findings resonate with parallel research, notably Barron et al.'s (2017) exploration of community mental health nurses in Scotland. Shared themes demonstrate the multifaceted nature of compassion within healthcare settings. Both studies illuminate the intricate understanding and interpretation of compassion among healthcare professionals, examining the nuanced perspectives that shape their caregiving roles. The identified theme of 'stifling compassionate services' delves into barriers that impede optimal care, whether stemming from institutional challenges or systemic issues. Additionally, 'the weight of the world' emerges as a common thread, emphasising the emotional burden and stress healthcare practitioners face in navigating challenging patient situations and broader healthcare pressures. The theme of 'getting nothing back' addresses the emotional fatigue experienced when compassionate efforts go unrecognised or unrewarded. Finally, the shared theme of 'looking after each other' highlights the importance of peer support and collaboration in maintaining compassion and well-being within the healthcare profession. These recurring themes not only authenticate the experiences of healthcare professionals but also contribute to a comprehensive understanding of the universal challenges inherent in providing compassionate care.

This study has offered insights into often-overlooked aspects of compassion. That compassion does not always have to be a 'grand gesture' where you solve complex issues or cure or aid suffering for others. While it can be these things, it is also being open and non-judgemental, taking time to turn up for and be present for and engaging in the more minor, everyday acts of relational support. It has also highlighted the importance of self-compassion and how self-awareness and reflection in a noncritical way can also aid your compassion for others.

Counselling psychologists who work within the NHS and complex services with complex staff and patient dynamics may find this study's findings beneficial for themselves and their nursing and support worker colleagues in these services. Utilising counselling

psychology strengths of self-awareness and self-reflection (MacDevitt, 1987) and encouraging these conversations and practices on the ward whilst also implementing strategies to aid nurses and healthcare support workers to have open conversations may also help them to maintain their compassion.

The themes of compassion identified in my thesis hold significant implications for counselling psychologists who assume leadership roles within the NHS. The relational aspect of compassion, as revealed in my research, guides leaders in fostering positive connections with colleagues, staff, and patients. Building strong relationships within the healthcare team aligns with the emphasis on feeling understood and providing emotional support, contributing to a supportive work environment and enhancing overall well-being.

Moreover, the personal aspect of compassion, emphasising self-reflection and awareness, is crucial for leaders. My study suggests that a leader's ability to navigate their own emotions and experiences influences their capacity to extend compassion to others. This self-awareness is valuable for leaders, contributing to better decision-making, empathy, and a compassionate leadership style that inspires and motivates the team.
The contextual aspect of compassion, addressing barriers and challenges, is particularly relevant for leaders within the NHS. My thesis highlights the importance of understanding and addressing systemic issues and institutional challenges, providing leaders with insights to create an environment that supports the well-being of healthcare professionals and the delivery of compassionate care to patients.

Practically, this study offers counselling psychologists in leadership roles a framework for cultivating compassion within the healthcare leadership context. It provides a nuanced understanding of compassion beyond traditional definitions, emphasising the everyday aspects and challenges healthcare professionals face. Leaders can use this knowledge to implement strategies that promote a compassionate workplace culture, address systemic barriers, and enhance the overall quality of care their teams provide.

I hope to revise inflexible and unhelpful policies and procedures, which can be changed based on the feedback from staff from this study and patient feedback gathered within these services. To create compassionate cultures within these services, the primary focus should be supporting and aiding staff rather than criticising or penalising them (Lewis, 2006). If compassion is to be deeply ingrained in the culture, the individuals within that culture must also be treated with compassion. This thesis highlights the critical role of self-compassion and self-reflection for healthcare professionals, particularly counselling psychologists, in cultivating a compassionate work environment. The emphasis is placed on the relational and personal aspects that contribute to compassionate care. McPherson et al.'s (2016) grounded theory study, exploring nurses and healthcare support workers in inpatient dementia services, supports and extends these notions. Their findings suggest that relying solely on recruiting individuals with inherent compassion or providing training may not substantially improve compassionate care. Instead, McPherson et al. advocate for organisational changes that exemplify and reward self-compassion and integrate self-compassion and mindfulness into staff training. This aligns with my thesis, reinforcing that a comprehensive strategy encompassing organisational shifts and individual mindfulness is crucial for enhancing compassionate care in healthcare settings.

This study aspires to extend the impact of its findings to influence the policies and practices of other health boards. Discussions have occurred with Sir Al-Aynsley Green, England's former children's commissioner and a leading advocate for children's rights. He has personally witnessed the challenging effects of a lack of compassion in dementia care through his late wife's experience. Sir Al-Aynsley Green is determined to contribute to addressing the compassion crisis in the NHS in England and Wales. We hope that, collectively, Richard Cheston (DOS), Sir Al-Aynsley Green, others, and I can explore avenues to address and ameliorate the compassion crisis within the NHS.

In conclusion, the implications for practitioners drawn from this research present a nuanced and multifaceted approach to enhancing compassionate care within the NHS. The identified themes, encompassing compassion's relational, personal, and contextual aspects, offer practical insights that extend beyond traditional perspectives. By emphasising the importance of self-compassion, self-reflection, and everyday acts of

relational support, this study provides a foundation for practitioners, particularly counselling psychologists and leaders within the NHS, to foster compassionate work environments.

The collaborative efforts and insights shared in this chapter contribute to a holistic understanding of the challenges and opportunities in cultivating compassion within healthcare settings. The findings highlight the need for systemic changes and advocate for leadership approaches that prioritise support over criticism and recognise the emotional burden healthcare professionals carry. This approach aligns with the broader goal of creating compassionate cultures within healthcare organisations.

The practical application of these insights involves revising inflexible policies, fostering open conversations, and prioritising support mechanisms over punitive measures. Counselling psychologists, equipped with their strengths in self-awareness and self-reflection, play a pivotal role in implementing these changes. Furthermore, the collaboration with advocates like Sir Al-Aynsley Green and others offers a promising avenue for influencing policies and practices beyond the immediate scope of this study. Ultimately, the implications for practitioners emphasise the potential for transformative change within the NHS. By prioritising compassion, fostering supportive environments, and acknowledging the challenges faced by healthcare professionals, this research seeks to contribute to a culture where empathy and understanding flourish, benefiting practitioners and, most importantly, the patients they serve.

Study Reflection

In the reflective examination of this study, it becomes evident that the qualitative nature of the research provided a rich and detailed exploration of participants' perspectives on compassion within the NHS. What worked well was the reflexive thematic analysis (TA) approach, allowing for an in-depth understanding of the complexities inherent in the concept of compassion. Incorporating a diverse range of participant voices added depth to the findings, although a noteworthy consideration arises concerning the participant group's predominantly white and Western composition. This prompts an awareness of

potential cultural variations in conceptualisations of compassion, suggesting the need for more inclusive representation in future research (discussed below). The reflexive practices employed throughout the study were essential in navigating the inherent subjectivity of the researcher. Recognising my role in shaping the research, I consistently reflected on and documented my assumptions and values, ensuring they did not limit engagement with the data. This reflective process became integral to the study, offering insights into compassion within the NHS and the nuances of qualitative research in healthcare settings. The learning from this research highlights the importance of ongoing reflexivity and cultural sensitivity, encouraging researchers in similar fields to actively reflect on their assumptions, engage diverse perspectives, and remain attuned to the potential influence of their subjectivity on the research process.

I have come to recognise the vastness and intricacy of the topic of compassion, a complex and diverse subject in its own right. Simultaneously, the National Health Service (NHS) operates as a sprawling and intricate organisation, encompassing numerous staff members, services, patient groups, and intricate policies and procedures. Delving into the realm of Older Persons Inpatient Mental Health Services introduced an additional layer of complexity, catering to older individuals with mental health issues and/or those diagnosed with dementia. Dementia itself is a multifaceted diagnosis with a spectrum of symptoms and complications affecting both the diagnosed individuals and their caregivers. Managing the three intertwined layers in this study presented challenges during data analysis and interpretation. While exploring each factor individually yielded rich data, integrating their relationships resulted in many intersecting complexities. It was imperative to consistently refocus on compassion as the primary study exploration amid the broader NHS landscape and the intricate domain of dementia. The multifaceted nature of this study offers insights into potential avenues for future research within each of these sections while also prompting reflection on the challenges encountered. Considering that different organisations or services might have presented fewer complexities, the decision to study the NHS was justified, driven by the urgent need to address the observed lack of compassion in healthcare, particularly in the context of the recent surge in compassionate research.

Directions for future research

Diversity in cultural perspectives is pivotal for a comprehensive understanding of compassion within healthcare settings, as cultural nuances significantly influence the interpretation and manifestation of compassionate care. The predominance of Western and white participants in this study highlights the necessity for future research to include individuals from diverse cultural backgrounds intentionally. Research suggests that cultural variations impact perceptions of compassion, influencing the expression and reception of empathetic caregiving. For instance, a study by Singh, King-Shier and Sinclair (2018) explored cultural differences in compassion, revealing distinct cultural norms shaping expectations and expressions of compassion. The inclusion of participants from various cultural backgrounds is crucial for uncovering these nuances and ensuring that findings are applicable across diverse healthcare contexts. Moreover, research by Plaisime, Jipguep-Akhtar and Belcher (2023) emphasises the importance of cultural competence in healthcare, highlighting how cultural differences affect the quality of care and patient satisfaction. Therefore, future studies in compassion within healthcare should deliberately incorporate a diverse range of participants to illuminate cultural influences on the understanding and practice of compassionate care.

Expanding the focus beyond nurses and healthcare support workers to encompass various staffing groups within older persons' inpatient mental health services could offer a more holistic view. This includes physiotherapists, psychiatrists, doctors, psychologists, occupational therapists, clinical administrative staff, and catering staff. Each role plays a unique part in patient care, and understanding how different disciplines perceive and contribute to compassionate care is crucial. Furthermore, future research could delve into the perspectives of patients and their caregivers or family members regarding compassionate care within these services. This study exclusively gathered the views of staff members, and exploring the reciprocal perceptions of patients and their support networks would enrich our understanding of the dynamics of compassionate care in healthcare settings. Drawing from diverse cultural perspectives and involving various

stakeholders in future research can contribute to a more nuanced and comprehensive exploration of compassion within healthcare.

Conclusion

This study provides a nuanced exploration of compassion within the healthcare context, elucidating three pivotal factors—relational, contextual, and personal—that collectively shape the understanding and manifestation of compassion. These factors shed light on the multifaceted nature of compassion and offer valuable insights into the determinants influencing compassionate actions. When applied to a healthcare setting, this framework provides a comprehensive understanding of how healthcare professionals perceive and enact compassion and unveils the intricate dynamics that may drive or impede compassionate care delivery. By examining the relational dynamics between staff, their contextual challenges, and the personal factors influencing their responses, the study offers a holistic perspective that can inform targeted interventions and policies to enhance compassionate care within the healthcare system. The study's findings emphasise the importance of addressing these diverse facets to foster a compassionate healthcare environment. The study sheds light on the pervasive lack of compassion within the NHS, attributing this deficiency to various factors. Insufficient resources, a lack of support mechanisms, and a deficit in relational awareness across all staff levels contribute to this challenge. Notably, the presence of a supportive leader emerges as a critical factor in fostering compassion among staff, acting as a shield against the often unhelpful and critical pressures originating from macro-level governance and management. The study highlights the importance of cultivating a compassionate leadership approach. However, it goes beyond individual leadership and advocates for broader structural changes within the NHS. This entails the integration of compassion into policies, procedures, and practices throughout the healthcare system. The call for systemic change reflects a recognition that true transformation necessitates a comprehensive, organisation-wide commitment to embedding compassion at every level of healthcare delivery.

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Appendices

A. Interview Topic Guide

UWE Bristol University of the West of England

Interview Guide

Version 3 – 29.10.2021

Role:

Age:

Time spent Working:

Organisational Questions:

1. How would you describe working for the NHS, what is it like?
2. What is it like working with OPMH inpatient services?
3. How do you feel you are treated as a member of staff within the NHS?

Ward Questions:

1. Tell me about your work/a typical day at work?
2. What are some of the challenges that you face?
3. What aspects make the job feel rewarding?

Compassion Questions:

1. Can you think of a time when you delivered compassionate care?
2. Can you think of a time when you received compassion from a colleague?
3. Can you think of a time when you experienced compassion from the organisation?
4. Do you have any examples of where you felt you lacked compassion and why you think this happened?
5. Have you witnessed a lack of compassion?
6. Has COVID affected your ability to be compassionate
7. COVID affected the organisations' compassion towards you? If so, in what way?

End with clean up question – anything else?

B. Flyer Advertisement

University of the West of England
BRISTOL

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

PARTICIPANTS NEEED

COMPASSION WITHIN THE NHS

Compassion is the core value of the NHS, but it can be hard for staff to deliver this consistently.

I believe that staff who work within mental health inpatient services should be provided with the opportunity to have their say on what their experiences are of working within these services. Recent staff surveys demonstrate burn-out, bullying and a lack of compassion from the leaders within the NHS.

Participants are required for research looking into compassion in the NHS

Are you a mental health nurse, clinical lead, ward manager or health care support worker?

Do you currently work on an older persons inpatient ward?

I want to hear **YOUR** thoughts and experiences of working within SBUHB

PLEASE CONTACT ME ON rebecca6.richards@live.uwe.ac.uk OR 07914753598

Your participation will be confidential and anonymous

C. Participant Information Sheet

Participant Information Sheet

Version 3 – 29.10.2021

Compassionate Care: Exploring NHS Mental Health Nurses and Nursing Assistants' Understanding and Experience of Compassion on Older Persons Inpatient Wards.

Study Sponsor

Study Host

You are being invited to take part in some research. Before you decide whether or not to participate, it is important for you to understand why the research is being conducted and what it will involve. Please read the following information carefully.

What is the purpose of the research?

I am conducting research to explore nurses and nursing assistances own perspectives and experience of compassion whilst working on older person's inpatient wards within the Swansea Bay Health Board. The focus is to explore staffs professional and personal experience of receiving and delivering compassion within the workplace.

Who is carrying out the research?

The data is being collected by myself, Rebecca Richards as a Trainee Counselling Psychologist for the purpose of my Doctoral Research.

What happens if I agree to take part?

The research will require you to take part in an interview where you will be asked to talk through your experiences of receiving compassion from the health board and colleagues as well as to discuss your own personal thoughts, opinions and experience of delivering compassionate care. You will be briefed before and after the interview. If you require any additional information, feel free to ask questions at any point of the session. If you feel affected by any issues raised in the interview, then additional support will be made available.

Is participation voluntary and what if I wish to later withdraw?

Your participation is entirely voluntary – you do not have to participate if you do not want to. If you decide to participate, but later wish to withdraw from the study, then you are free to withdraw within four weeks of completing the interview, without giving a reason.

If you would like to ask any further questions, please feel free to contact me (contact details are at the bottom of this information sheet).

What will happen to the information I provide?

All information you provide will only be used as part of this study, and not for any other purpose. The information you provide will not be shared with any of your colleagues, or managers, unless we think it is necessary to protect your health and wellbeing or to protect the health and wellbeing of someone else.

D. Participant Consent Form

Study Sponsor

Study Host

IRAS ID: 296475

Participant Identification Number for this trial:

CONSENT FORM

Version 2 – 29.10.21

Title of Project: Compassionate Care on Older Persons Mental Health Inpatient Wards.

Name of Researcher: Rebecca Richards

Due to the multi-method approach of interviews (face-to-face, telephone and online) and with some participants potentially not having the equipment to electronically sign for consent, your consent to participate will be given verbally at the start of the interview and will be audio recorded. If you have any questions please contact a member of the research team, whose details are set out on the Participant Information Sheet.

Please read the following before verbally giving your consent to participate;

1. I confirm that I have read the information sheet dated 29.10.2021 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I agree for my contact details to be retained so that I can be updated about the outcome of the study

4. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.

5. I agree to take part in the above study.

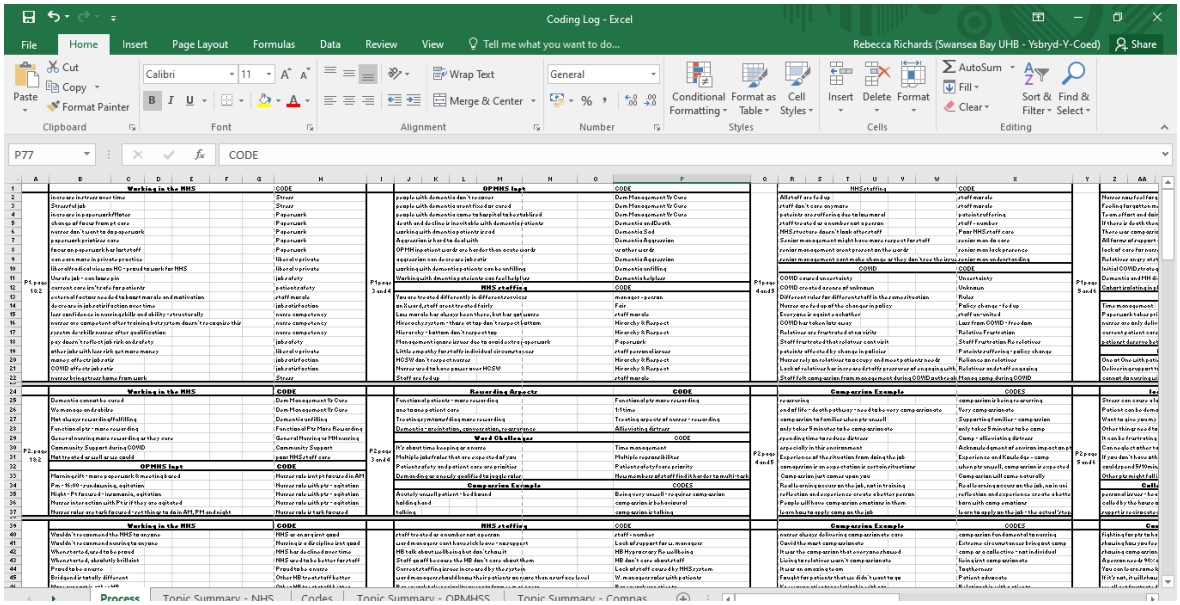
Researcher signed to confirm that the above has been read and discussed prior to the interview, and an audio recording of verbal consent has been obtained.

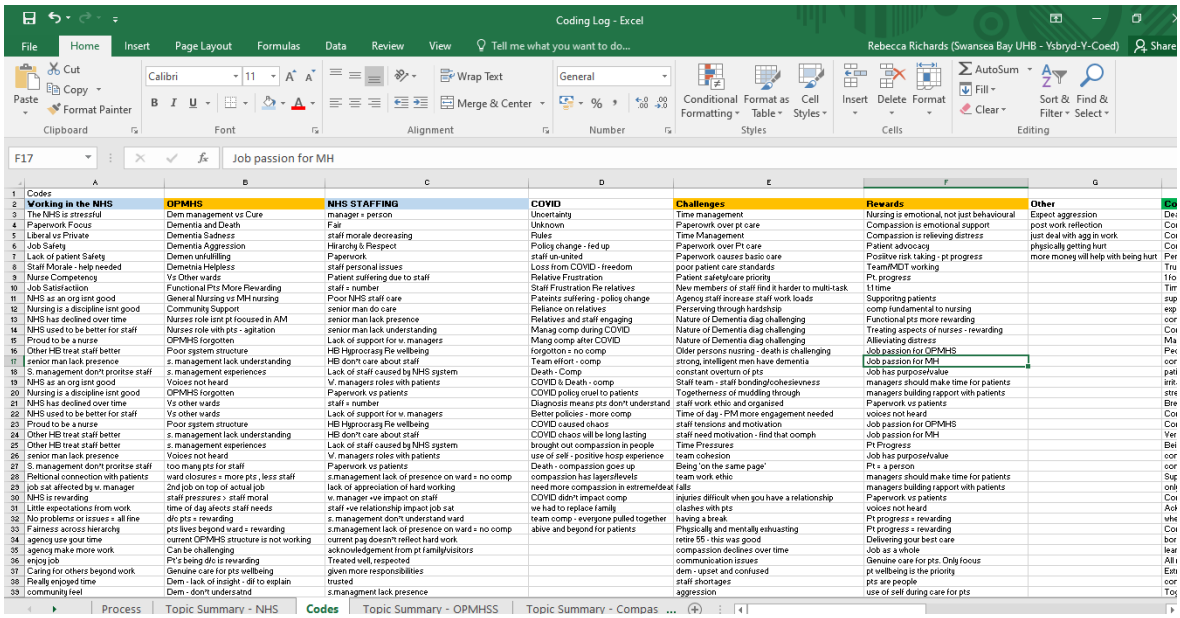
Name: _____ Date: _____

Signature: _____

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

E. Example of Coding





F. Research Ethics Committee Approval

Faculty of Health & Applied Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

Our ref: JW/lt

17th November 2021

Miss Rebecca Richards

Dear Rebecca

Application Number: HAS.21.11.028
Application title: Compassionate Care: Exploring NHS Mental Health Nurses and Nursing Assistants' Understanding and Experience of Compassion on Older Persons Inpatient Wards
REC reference: 21/HCRW/0034
IRAS project ID: 296475

Your NHS Ethics application and approval conditions have been considered by the Faculty Research Ethics Committee on behalf of the University. It has been given ethical approval to proceed with the following conditions:

- You comply with the conditions of the NHS Ethics approval.
- You notify the Faculty Research Ethics Committee of any further correspondence with the NHS Ethics Committee.
- You must notify the Faculty Research Ethics Committee in advance if you wish to make any significant amendments to the original application.
- If you have to terminate your research before completion, please inform the Faculty Research Ethics Committee within 14 days, indicating the reasons.
- Please notify the Faculty Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.
- Any changes to the study protocol, which have an ethical dimension, will need to be approved by the Faculty Research Ethics Committee. You should send details of any such amendments to the committee with an explanation of the reason for the proposed changes. Any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.
- Please note that the Research Ethics Sub-Committee (RESC) is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the RESC and its committees.

Please note that your study should not commence at any NHS site until you have obtained final management approval from the R&D department for the relevant NHS care organisation. A copy of the approval letter(s) must be forwarded to Leigh Taylor in line with Research Governance requirements.

G. HRA Approval

Prof Richard Cheston
Professor of Dementia research
University of the West of England
Health and Social Sciences
3A07, Frenchay Campus
Bristol
BS161QYN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

02 November 2021

Dear Prof Cheston

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Compassionate Care: Exploring NHS Mental Health Nurses and Nursing Assistants' Understanding and Experience of Compassion on Older Persons Inpatient Wards.**
IRAS project ID:	**296475**
Protocol number:	**N/A**
REC reference:	**21/HCRW/0034**
Sponsor	**University of West England**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

H. Excerpts from Reflection Diary

‘This appendix has been removed as it contains personal information.

I. UWE Risk Assessment

University of the West of England BRISTOL

GENERAL RISK ASSESSMENT FORM

Ref:

Describe the activity being assessed Face-to-face, video-call (Teams) and/or telephone interviews with NHS nursing and nursing assistant staff within older persons mental health services about their experiences of working on the ward in realtion to delivering and maintaining compassionate care. Interview questions may also discuss participants self compassion and how they feel this, as well as compassion from colleages may have or could affect the care that they are able to deliver to patients.	**Assessed by:** Victoria Clarke	**Endorsed by:** Zoe Thomas
Who might be harmed: Participants and researcher **How many exposed to risk:** 10-15 participants + 1 researcher	**Date of Assessment:** 05.11.2021	**Review date(s):** 05.11.2022

Hazards Identified *(state the potential harm)*	Existing Control Measures	S	L	Risk Level	Additional Control Measures	S	L	Risk Level	By whom and by when	Date completed
Participant Distress	Should participants become upset or distressed during the interview, the interview will be paused and participants will be offered a break. Participants will be offered a choice to pause the interview and continue at a later date, to terminate the interview and their participation or to continue. All participants will be given the information for the staffs wellbeing services and advised to contact them for any support they may need. Participants will also be provided with the DOS's details who can be contacted if participants are distressed due to their participation in the study. The DOS is a psychotherapist with over 30 years-experience as a clinical psychologist within the NHS. Should participants self-disclose abusive care, or care of concern, or if participants disclose abusive care that they have witnessed from other staff members, as stated in the participant information sheet, it will be discussed with the participant about the best course of action as to how this can be taken forward and if necessarily raised as a safeguarding concern following the health boards safeguarding procedure and	1	3	3	N/A					
	relevant managers will be informed. All concerns, worries, issues or any potential upset and risk will be discussed with the chief investigator immediately. The healthboards safeguarding and whistleblowing policy will be adhered to.									
Researcher lone-working	Any face-to-face interviews will be carried out on an NHS site, should I, RR, the researcher require any immediate support, I can contact near-by staff, call the emergency duty contact number for the healthboard, or contact emergency services. The standard safety buddy protocol will also be followed.	1	2	2						
Researcher Distress	I, RR, the researcher can contact the DOS Richard Cheston as well the second supervisor Victoria Clarke for support if required. I, RR, the researcher is also aware of the staff wellbeing services and how to access these if necessary. The UWE lone working policy (G033) as well as the health boards lone working policy will be adhered to and will be integral to the implementation of all aspects of the project. UWE's safety for social research guidance (G017) will also be adhered to.	1	3	3						
COVID-19 Infection when conducting face-to-face interviews.	Throughout the fieldwork period, the researcher will follow any relevant UWE, health board and local government and national government guidance regarding covid safety measures. The researcher, RR, is currently undergoing twice weekly lateral flow tests as according to UWE and the health board guideance. The researcher, RR has also received both vaccinations along with the booster vaccination.	2	2	4						

	It is highly, that as participants are staff within the healthboard, they also are undergoing twice weekly lateral flow tests and it is also highly likely that participants will also have received their covid-19 vaccinations. Researcher, RR will wear a face mask whilst conducting the interview, ensure social distancing is adhered too and the room is ventilated (open window).									

RISK MATRIX: (To generate the risk level).

Very likely 5	5	10	15	20	25
Likely 4	4	8	12	16	20
Possible 3	3	6	9	12	15
Unlikely 2	2	4	6	8	10
Extremely unlikely 1	1	2	3	4	5
Likelihood (L) ↑ / → **Severity (S)**	**Minor injury – No first aid treatment required** 1	**Minor injury – Requires First Aid Treatment** 2	**Injury - requires GP treatment or Hospital attendance** 3	**Major injury** 4	**Fatality** 5

ACTION LEVEL: (To identify what action needs to be taken).

POINTS:	RISK LEVEL:	ACTION:
1 – 2	NEGLIGIBLE	No further action is necessary.
3 – 5	TOLERABLE	Where possible, reduce the risk further
6 - 12	MODERATE	Additional control measures are required
15 – 16	HIGH	Immediate action is necessary
20 - 25	INTOLERABLE	Stop the activity/ do not start the activity

I. Email for recruitment support via senior management

This appendix has been removed as it contains personal information.

Journal Article for Submission

Word Count: 5102

The Nuance of Compassion: An exploration using reflexive thematic analysis of how NHS staff working in Older Person's Mental Health talk about their experience and understanding of compassion

Rebecca Wilson, Richard Cheston and Victoria Clarke
University of the West of England

ABSTRACT: In the heart of healthcare, the National Health Service (NHS) derives vitality not only from medical expertise but also from a crucial, often overlooked force: compassion. Despite being a core value in Welsh healthcare, instances of lacking compassion, notably in cases like the Staffordshire inquiry, have led to calls for patient-centered care. This study, rooted in "A Healthier Wales: Our Workforce Strategy," explores nurses' and support workers experiences in older persons mental health services in Wales, uncovering three themes: "Compassion is Relational," emphasizing its role in shaping relationships; "Compassion is Contextual," revealing its variations due to cultural and situational factors; and "Compassion is Personal," exploring individual experiences influencing self-compassion. The research underscores that compassion involves both grand gestures and everyday acts, emphasizing the importance of self-compassion and non-critical reflection in enhancing care.

BACKGROUND

At the heartbeat of healthcare, the National Health Service (NHS) draws its vitality from not only medical expertise and cutting-edge technology but also from an often-overlooked force, that defines its very essence: compassion. Stripped of compassion, the NHS becomes a mechanised entity of procedures and prescriptions, lacking the human touch that elevates it beyond a mere institution to a vital lifeline for millions. Caring for the health and well-being of others is intrinsically compassionate behaviour (West, 2017) with compassion being one of the core values of health care within Wales (wales.nhs.uk, 2020).

Yet, some have noted, experienced and claim there to be a compassion crisis within the NHS (REF SIR Al, Trz book) but also society more broadly, with some claiming that the moral compass of society has lost its coordinates of compassion, civic good and, universal comfort and protection. With self-interest, consumerism and individual responsibility promoted in their place (Cromby et al, 2022). An inquiry into the care provided by the Mid Staffordshire NHS Trust between 2005 and 2009 has highlighted the impact that poor care quality can have on its patients. The Staffordshire inquiry, which witnessed a significant increase in patient death rates, shed light on how the absence of compassionate care can result in patient suffering. It concluded that there was a requirement for care that is more patient-centred and compassionate (Francis, 2010). From this, the campaign Cure the NHS (2013) was formed by relatives of patients who were treated at Mid-Staffordshire NHS in a bid to improve the care that was being delivered across the NHS. The Francis Report (2013) examined the causes of the failings in care at the hospital and made 290 recommendations, of which, an increase and need for compassion within healthcare and leadership within the NHS were stated. This inquiry proposed how a lack of compassion can result in significantly poor quality of care and the detrimental effects this can have on patients.

Many claim that compassion in healthcare offers numerous benefits for staff, patients, and the organization. For example, receiving compassion can lead people to experience positive emotions such as gratitude, pride and inspiration. (Lilius et al, 2008). When healthcare staff treat patients with

compassion, patients are more satisfied, which in turn has an impact on staff well-being (Clyne, 2018), patients describe feeling compassion when they feel known by nurses, and when nurses spend time with them despite the appearance that they do not have the time to give (Dwerer and Nolan, 2013). Moreover, research indicates that caregivers are more likely to establish a connection with their patients (Kahn, 1998) and deliver holistic care that addresses the entire person rather than merely the illness (Brody, 1992; Cassell, 2002) when they exhibit compassion.

Previous complaints and investigations highlight the potentially detrimental effects of healthcare services lacking compassion on patient care. Conversely, research indicates the positive influence that compassion can wield on both an organisation and the individuals—both staff and patients—associated with it. The mentioned studies and initiatives emphasize the significance of staff within healthcare services receiving and experiencing compassion not only from their colleagues but also from the organisation itself.

AIM

This research thesis was designed to gain a greater understanding of mental health nurses' and healthcare support workers' experience of working in an older person's mental health in-patient ward in Wales. This study aimed to explore nurses' experience and awareness of their personal, professional and organisational compassion, and, their views on how this may affect both patient care and job satisfaction.

Research Questions

This study addresses the following research questions:

i) How do nurses and healthcare support workers working in OPMH inpatient wards within SBUHB understand and make sense of compassion?

ii) What is their personal and professional experience of compassion within the health board and over their career?

METHOD

A qualitative methodology was considered the most appropriate for aligning with the research aims, utilizing interviews to collect data from nurses and healthcare support workers in an older persons' mental health inpatient ward at Harborview Health System. The collected interview data was transcribed, and reflexive thematic analysis (TA) was chosen as the analytical method, following Braun and Clarke's approach (2006, 2022). Qualitative methodology proves well-suited for investigating complex and multifaceted psychological phenomena, such as compassion. It enables an in-depth exploration of experiences, perceptions, and behaviours, offering flexibility in data collection methods. Moreover, qualitative research places a strong emphasis on understanding participants' perspectives, a crucial aspect in counselling psychology where the lived experiences and voices of individuals are central to the research inquiry (Creswell et al., 2007). As a researcher in the counselling psychology discipline who is new to qualitative methodologies, thematic analysis initially provided space for understanding, learning, and reflecting on ontological and epistemological beliefs within and outside of research. Thematic analysis's flexibility allowed exploration of philosophical positioning in relation to the research project, offering room to reflect on more positivist as well as more contextual perspectives, ultimately leading to a critical realist position.

The choice of interviews as the data collection method was based on their ability to facilitate a rich, in-depth exploration of the research topic (Braun and Clarke, 2013). Interviews allow for probing deeper into participants' thoughts, feelings, and experiences, providing a comprehensive understanding. They also offer an opportunity to understand the context surrounding participants' experiences, aligning with the critical realist stance. The ability to ask follow-up questions allowed for insights into the social, cultural, or environmental factors influencing compassion. The flexibility of adapting questions based on participants' responses made the process dynamic and responsive to emerging insights. Face-to-face interviews, both virtual and in-person, provided an opportunity to

establish rapport with participants, contributing to more open and honest responses and enhancing the trustworthiness of the data (Johnson, Adkins, and Chauvin, 2020).Theoretical Standpoint

Woolfe, Dryden, and Strawbridge (2003) argue that the philosophical underpinnings of counselling psychology are grounded in humanistic, existential, and phenomenological values that seek to explore understanding and meaning while placing subjective experience and beliefs at the core. Similar to psychological research, psychological practice encompasses various stances, beliefs, and approaches that psychologists may adopt. From a pluralistic counselling psychology perspective, mental health is seen as a concept with multiple meanings, theories, and understandings. The belief is that symptoms offer insights into the reality of mental health, and language serves as a means to communicate and comprehend these symptoms and experiences. The interpretation and understanding of language, however, depend on an individual's social, cultural, conscious, and unconscious experiences. In other words, two individuals describing similar symptoms may interpret, understand, and hold different beliefs about their symptoms, with both experiences being equally real to each person.

Consequently, this research takes a broadly experiential approach, guided by a critical realist perspective (Wiltshire and Ronkainen 2021). Experiential approaches aim to capture participants' experiences and perspectives, grounding the research in their accounts rather than the researcher's categories, while still recognizing language as a reflection of "internal categories of understanding" (Reicher, 2003: 3). A critical-realist perspective focuses on exploring how individuals make sense of their personal experience and understanding, considering both the broader social context and how their representations of reality may be shaped by it (Maxwell, 2012). The assumption is that participants possess insight into their own experiences, but these insights may be influenced by the culture of the hospital ward, social interactions within that environment, and their own culture, language, and political interests (Braun and Clarke, 2023).

Ethics

Ethical approval was obtained from the University's Research Ethics Committee. Informed consent was collected verbally, and participants were assured of confidentiality and support for any distress. Disclosure of abusive or neglectful care would have been addressed following the health board's safeguarding policy.

Data Analysis

Data collected from interviews were analysed using Braun and Clarke's (2022) model of TA, which included the following six phases: Familiarisation; Transcripts were reviewed, corrected, and then immersed into the data. The researcher critically engaged with the data, considering participants' perspectives and underpinnings. Generating Initial Codes; Initial coding began at a semantic level, identifying explicit meanings in the data. Later, latent coding was employed, capturing implicit meanings and generating codes. Coding was managed using both paper and electronic formats, and codes were grouped into themes. Generating Initial Themes; Initial themes were developed, capturing the essence of the dataset. However, these themes initially focused more on organizing codes rather than conveying the data's narrative. Developing and Reviewing Themes; The focus shifted to understanding the data's narrative and how initial themes represented it. Visual mapping of codes and themes helped identify relationships and refine themes. Refining, Defining, and Naming Themes; Themes were refined, defined, and named to better represent the data's narrative, often using direct quotations from participants to maintain proximity to their accounts. Writing Up; In the final phase, the analysis was deepened as the research findings were written. Direct quotations were used to connect participants' narratives to the analysis, ensuring alignment.

Reflexivity

An intervention that encourages reflexivity and facilitates the capture of thoughts and perceptions, thereby developing an understanding of one's role in the research, is a research diary (Parker, 2005). Throughout the research, a research diary was maintained, providing a space to become self-aware of any thoughts, emotions, and feelings that influenced behaviour within interviews, as well as how

themes were viewed, shaped, and created throughout the data analysis. In the training as a counselling psychologist, a great deal of self-reflection has been undergone through the received teaching, the completion of personal therapy, and the experience gained in placements and work within various NHS services. Throughout the course, tutors consistently emphasize the inherent subjectivity of individuals, influenced by prejudices, expectations, judgments, reactions, and personal experiences. When stepping into the therapy room with a client, all these aspects are carried along. There is an encouragement to delve into self-awareness to comprehend the dynamics of transference and countertransference, intra-psyche defences, and how they manifest and interact with the client within the therapeutic space. The concept of self-awareness and self-reflection has been applied to the role as a researcher. The research diary is not merely a collection of research notes; it is an inseparable part that encapsulates identity and how personal situations influence thoughts, emotions, and behaviours—both consciously and subconsciously—throughout the research journey. Consequently, there has been a concerted effort to remain open and inquisitive, continuously exploring subjectivity. This allows awareness and acknowledgement of its presence, not only within the research but also in all aspects of life.

FINDINGS

Analysis of the data relating to participants' descriptions of compassion resulted in the development of three overarching themes. The first theme, Compassion is Relational, includes how compassion influences and shapes relationships with patients, colleagues, managers and people in general. Within this theme, three subthemes were created; i) "We are just numbers, they don't care, ii) Togetherness: "Everybody helps each other out", and iii) Genuine desire to care. The second theme, Compassion is Contextual, highlights how compassion can vary between cultural, social and individual factors, but how it can also be affected by environmental and situational factors such as workplace ambience and the nature of the diagnosis. Within this theme, three subthemes were created; i) Compassion or efficiency, ii) The toll of caring: Compassion fatigue in dementia care, iii) Existential Angst. The final theme, Compassion is Personal, includes a person's experiences, beliefs, and values and how these can shape and determine their ability to form self-compassion. Within this theme, three subthemes were created; i) Wounded healers, ii) The Compassionate Slef: Mindfulness, Empathy and Self-Reflection, iii) "It's just who I am, it's innate.

Compassion is relational. Compassion plays a crucial role in interpersonal relationships within healthcare settings. Participants in a study emphasized the significance of connection, respect, and mutual understanding in determining the level of compassion they experienced. Building and maintaining relationships with colleagues, patients, and their families were seen as essential for fostering compassionate practice. The absence of a connection with senior management led to a lack of compassion, while support and understanding from ward managers enhanced a sense of togetherness and compassion among the staff. Some participants found it challenging to maintain compassion due to a lack of connection, support, and respect from their superiors. This theme contains three sub-themes: "We are just numbers, they don't care" Participants described feeling a lack of compassion from senior management, emphasizing the importance of their presence and connection. The absence of a relationship with senior management resulted in a feeling of being treated as mere numbers. This lack of understanding and respect from senior management affected their morale and overall perception of compassion within the organization. The second subtheme; Togetherness; "Everybody helps each other out" Participants highlighted the significance of teamwork and team cohesion, which created a sense of safety and support. Compassion within the team fostered a sense of belonging and mutual care. Compassionate colleagues and ward managers positively impacted job satisfaction, reducing stress and enhancing overall well-being. The final sub-theme; Genuine desire to care. Staff expressed the rewarding aspect of their job as forming meaningful relationships with patients. Compassion was vital in establishing these connections, and participants mentioned instances of patients reciprocating this compassion. Staff's ability to be compassionate towards patients was influenced by the compassion they received from their colleagues and superiors. Compassion had a profound impact on patient care and outcomes, creating a positive environment where patients felt understood and supported. In summary, compassion is a relational concept that significantly affects healthcare professionals' interactions with colleagues and

patients. It fosters empathy, support, and understanding, strengthening interpersonal relationships, enhancing professional practice, and improving patient care and outcomes. Participants emphasized the importance of compassion in their workplace and how it could positively impact their well-being and job satisfaction, ultimately contributing to the quality of care they provide.

Compassion is contextual. The theme captures the multifaceted factors that influence the healthcare staff's ability to sustain compassion for both colleagues and patients within the complex environment of mental health wards. Participants in the study articulated considerations spanning environmental, cosmetic, spatial, and situational dimensions. Ward ambience, the demands placed on the ward, patient diagnoses, the duration of a patient's stay, and end-of-life pathways emerged as key influencers. Three discernible subthemes encapsulate the nuanced nature of these discussions: 1) Compassion or Efficiency, highlighting the tension between compassionate care and efficiency demands; 2) The Impact of the Diagnosis, emphasizing the profound influence of varied medical conditions on compassionate approaches; and 3) Existential Angst, capturing the complex emotional and existential challenges in end-of-life care and prolonged patient stays. The first subtheme, "Compassion or Efficiency," delves into the intricate dynamics of balancing compassion and efficiency within healthcare settings. Participants provided rich insights into the factors enabling compassionate care, including the time of day, task delegation, experiential wisdom, and patient-centred learning. The quotes underscore the delicate balance healthcare professionals must navigate, highlighting the interplay between time constraints, task demands, and the humanistic aspect of caregiving. Barriers to compassion were also discussed, with participants citing factors such as ward busyness, paperwork demands, and external stressors. The second subtheme, "The Toll of Caring: Compassion Fatigue in Dementia and Mental Health," explores the emotional strain and challenges faced by healthcare professionals, particularly in older persons' mental health wards. Compassion fatigue, characterized by a decline in empathy due to prolonged exposure to the suffering of others, was evident in participants' narratives. The differentiation in compassion levels across various diagnoses, particularly dementia, and the challenges posed by aggressive behaviours and confusion shed light on the nuanced toll of caregiving. The third subtheme, "Existential Angst," focuses on the existential challenges healthcare professionals face, especially in end-of-life care. The theme reveals that compassionate care reaches its pinnacle during these moments, as participants shared experiences of providing emotional support and ensuring comfort for patients on an end-of-life pathway. The discussion delves into the unspoken fears, uncertainties, and reflections on life's meaning that influence both the emotional well-being of individuals receiving care and the approach of healthcare professionals. Interestingly, participants predominantly associated their highest level of compassion with end-of-life moments, suggesting that these instances carry a unique weight in their understanding of compassionate care. While contextual factors were emphasized in facilitating compassionate care, the theme of death surfaced prominently in participants' reflections, evoking unconscious existential angst. This raises the possibility that healthcare professionals might not consciously recognize death as a factor enabling their compassion, instead focusing on the specific circumstances following a patient's passing. In conclusion, the explored theme provides a comprehensive view of the intricate factors influencing healthcare staff's ability to maintain compassion in mental health wards. The subthemes highlight the delicate balance between compassion and efficiency, the toll of caregiving with a focus on compassion fatigue, and the existential challenges associated with end-of-life care. The study contributes valuable insights into the complex interplay of factors that shape compassionate care within the healthcare environment.

Compassion is Personal: The overarching theme, "Compassion is Personal," intricately explores the multifaceted nature of compassion based on participants' interviews, encapsulating diverse dimensions through three subthemes: "Wounded Healing," "The Compassionate Self: Mindfulness, Empathy, and Self-Reflection," and "It's just who I am, it's innate." In the first subtheme, "Wounded Healing," participants reflect on personal encounters with adversity, pain, or loss, highlighting how these experiences deepen their comprehension of human suffering and cultivate a heightened sense of empathy. The transformative power of personal wounds is underscored, exemplified by individuals who have turned their own struggles into sources of strength, aligning with the psychological concept of the wounded healer. This archetype, popularized by Carl Jung, suggests that

individuals who undergo personal struggles develop a deeper understanding of human suffering, enhancing their effectiveness in helping others heal. The narratives resonate with existing psychological literature, emphasizing the role of personal adversity in fostering empathy and compassion in healthcare professionals. Transitioning to the second subtheme, "The Compassionate Self: Mindfulness, Empathy, and Self-Reflection," the exploration centres on the interplay of personal attributes contributing to compassionate care. Participants attribute their compassion to various practices, upbringing, and inherent traits. Some highlight the role of mindfulness practices, such as meditation and exercise, aligning with research that correlates mindfulness with extended compassion to others. The subtheme underscores the significance of self-reflection and mindfulness, echoing existing literature that identifies self-compassion as a key factor in boosting healthcare professionals' capacity to deliver compassionate care. The intricate relationship among mindfulness, self-reflection, and compassion emerges as a crucial foundation for extending empathy in healthcare environments. The third subtheme, "It's just who I am, it's innate," presents a contrasting perspective. Some participants expressed the belief that compassion is an intrinsic quality that one is either born with or without. This challenges conventional notions about the teachability of compassion, as participants question the authenticity of trained compassion. This perspective has implications for training programs and recruitment strategies in healthcare, advocating for the recognition and prioritization of individuals with an inherent capacity for compassion. The belief in the intrinsic nature of compassion aligns with developmental psychology studies suggesting an early emergence of empathetic responses in infants, hinting at a potential evolutionary basis for compassion. In summary, the theme "Compassion is Personal" intricately weaves together the diverse facets of compassion, exploring its origins in personal values, emotions, and life experiences. The subthemes collectively underscore the transformative power of personal wounds, the intricate interplay of mindfulness and self-reflection in cultivating a compassionate self, and the varying perspectives on the innate nature of compassion. This comprehensive exploration provides valuable insights into the nuanced understanding of compassion, emphasizing the need for healthcare professionals to integrate both personal experiences and inherent qualities in delivering empathetic and compassionate care. Recognizing the multifaceted nature of compassion can enrich training and recruitment approaches, fostering a more authentic and profound expression of compassionate healthcare.

Findings Summary: This analysis delves into the complexity of compassion and highlights the everyday aspects of this concept. Compassion is often seen as an act aimed at alleviating the suffering of others. However, participants in the study emphasize that compassion also involves feeling understood and supported during difficult situations. The analysis shows that compassion is a powerful tool for building positive relationships with colleagues, staff, and patients. It can also serve as a coping mechanism during challenging experiences and when relational connections are difficult to establish, such as with dementia patients. Moreover, self-compassion and self-reflection are essential for healthcare workers to navigate their emotions and experiences. This research reveals the nuanced and multi-faceted nature of compassion in healthcare.

DISCUSSION

The analysis of participants' interviews on compassion provides insights into the nuanced and everyday dimensions of this concept. Traditionally viewed as a behavioural response stemming from an awareness of others' suffering, compassion is often associated with a desire to alleviate that suffering. However, participants in this study emphasised the importance of feeling understood, having someone take the time to listen, and providing emotional support as integral components of compassion during difficult situations. This perspective is reinforced by those who experience compassion from their ward manager, showcasing the positive impact on their work experiences despite acknowledging its challenges.

The analysis also highlights the role of self-compassion and self-reflection in maintaining compassion among staff members. Three distinct aspects of compassion emerge the relational aspect, fostering positive connections with colleagues, staff, and patients; the contextual aspect, assisting during challenging experiences and overcoming barriers; and the personal side, emphasising the importance of self-reflection and awareness in navigating difficult emotions and experiences.

In summary, this research unveils the nuanced and everyday facets of compassion. The subsequent section will provide a condensed overview of the analysis before revisiting the research questions to discuss the analysis in relation to the research questions. The implications for counselling psychology, study reflections and evaluation, and potential future research needs will be discussed. The final section of the thesis offers a closing summary, emphasising the existence of three interconnected facets of compassion—relational, personal, and contextual—and their collective influence on individuals' capacity to extend compassion to themselves and others, particularly within the healthcare context. This study highlights the intricate nature of compassion, the absence of unanimous consensus on its definition, and the potential for effective expression through simple gestures.

How do nurses and healthcare support workers working in OPMH inpatient wards within SBUHB understand and make sense of compassion?

In exploring nurses' and healthcare support workers' understanding of compassion in OPMH inpatient wards within SBUHB, two main aspects emerge compassion as relational and compassion as personal, with contextual factors influencing its manifestation in healthcare settings. The relational underpinnings of compassion form a central theme, where participants consistently highlight the importance of connection, understanding, and support in their interactions with patients. This aligns with existing research emphasizing patients' feelings of compassion when known by nurses and the significance of time spent despite apparent constraints. Compassion, viewed as relational, extends beyond addressing needs to engage with patients as complete individuals, reflecting a deeper interpersonal interaction.The second theme, "Compassion is Contextual," delves into the impact of factors like the perception of dementia on forming relationships, aligning with Kitwood's emphasis on empathetic understanding in dementia care. Participants express the importance of knowing their patients, having time for them, and engaging in conversations to demonstrate compassion. The study resonates with Sinclair et al.'s focus on the depth of the healthcare provider-patient relationship as central to compassion. Furthermore, the role of reciprocity in relationships, explored through social psychology perspectives, offers insights into potential factors contributing to professional burnout when lacking in emotionally demanding contexts. The personal aspect of compassion encompasses individual differences, including spirituality, culture, values, experiences, and beliefs. The wounded healer concept, rooted in Jungian psychology, suggests that personal struggles and wounds cultivate empathy and understanding in healers, leading to a deeper connection with others. Stone's depiction of compassion as a transformative cycle from healer's wounds to recipients and back underscores the profound impact of personal experiences on compassionate care. Personal practices such as spirituality and mindfulness also emerge as factors influencing participants' capacity for compassion. Additionally, some participants perceive compassion as an inherent, unteachable quality ingrained in their biology and identity.

In conclusion, this study highlights the dual nature of compassion—both relational and personal—shaped by contextual influences. The findings underscore the significance of secure relationships and self-awareness in fostering compassion. Training and initiatives on compassion should prioritize these elements to equip healthcare professionals in extending genuine and empathetic care. The study's implications extend to healthcare practices, emphasizing the importance of understanding the nuanced impact of contextual factors and individual differences on the compassionate care provided by nurses and healthcare support workers in OPMH inpatient wards within SBUHB.

What is their personal and professional experience of compassion within the health board and over their career?

The third theme of this study explores contextual aspects influencing compassion among healthcare providers. Participants cited the NHS's efficiency-focused discourse and organizational demands as key factors affecting their ability to provide and sustain compassion. Challenges like understaffing, paperwork burden, and non-clinical care demands were common across four wards, with positive experiences of compassion linked to supportive ward managers. The strain on healthcare providers aligns with the concept of moral injury, involving internal conflict due to organizational constraints, as

highlighted by Haslam-Larmer et al. (2023) and Rowlands (2021). These studies underscore challenges in providing compassionate care and advocate for organizational reforms aligning with ethical aspirations, crucial for vulnerable populations like those with dementia. Within this theme, patient diagnosis, emotionally challenging situations, and caring for older individuals, especially those with dementia, emerged as additional factors influencing compassion. Piiparinen and Whitlatch's (2011) study explores existential loss in dementia caregiving, emphasizing its impact on well-being, while McKenzie et al. (2017) delve into death anxiety and coping strategies among health professionals in dementia care. These studies underscore the psychological toll of caregiving and stress the need to address existential aspects for comprehensive support and enhanced dementia care quality.

Lastly, personal factors, an integral dimension of compassion, were examined in relation to sustaining compassion in the workplace. Self-awareness of personal struggles enhanced empathy and compassion toward others. Participants valued the staff well-being service for debriefing and emphasized the importance of debriefing with supportive colleagues. The study highlights the significance of staff receiving compassion from colleagues and ward managers, positively impacting compassion maintenance, even in the absence of compassion from senior management or the health board. It offers insights into helpful strategies for staff working in these services to sustain compassion throughout their careers.

Implications for Practitioners

The implications for practitioners drawn from this research present a nuanced and multifaceted approach to enhancing compassionate care within the NHS. The identified themes, encompassing the relational, personal, and contextual aspects of compassion, offer practical insights that extend beyond traditional perspectives. By emphasising the importance of self-compassion, self-reflection, and everyday acts of relational support, this study provides a foundation for practitioners, particularly counselling psychologists and leaders within the NHS, to foster compassionate work environments. The collaborative efforts and insights shared in this chapter contribute to a holistic understanding of the challenges and opportunities in cultivating compassion within healthcare settings. The findings not only highlight the need for systemic changes but also advocate for leadership approaches that prioritise support over criticism and recognise the emotional burden healthcare professionals carry. This approach aligns with the broader goal of creating compassionate cultures within healthcare organisations. Moving forward, the practical application of these insights involves revising inflexible policies, fostering open conversations, and prioritising support mechanisms over punitive measures. Counselling psychologists, equipped with their strengths in self-awareness and self-reflection, play a pivotal role in implementing these changes. Furthermore, the collaboration with advocates like Sir Al-Aynsley Green and others offers a promising avenue for influencing policies and practices beyond the immediate scope of this study. Ultimately, the implications for practitioners emphasise the potential for transformative change within the NHS. By prioritising compassion, fostering supportive environments, and acknowledging the challenges faced by healthcare professionals, this research seeks to contribute to a culture where empathy and understanding flourish, benefiting not only practitioners but, most importantly, the patients they serve.

CONCLUSION

This study provides a nuanced exploration of compassion within the context of healthcare, elucidating three pivotal factors—relational, contextual, and personal—that collectively shape the understanding and manifestation of compassion. These factors not only shed light on the multifaceted nature of compassion but also offer valuable insights into the determinants influencing compassionate actions. When applied to a healthcare setting, this framework not only provides a comprehensive understanding of how healthcare professionals perceive and enact compassion but also unveils the intricate dynamics that may drive or impede compassionate care delivery. By examining the relational dynamics between staff, the contextual challenges they face, and the personal factors influencing their responses, the study offers a holistic perspective that can inform targeted interventions and policies aimed at enhancing compassionate care within the healthcare system. The

study's findings emphasise the importance of addressing these diverse facets to foster a compassionate healthcare environment. The study sheds light on the pervasive issue of a lack of compassion within the NHS, attributing this deficiency to a confluence of factors. Insufficient resources, a lack of support mechanisms, and a deficit in relational awareness across all staff levels contribute to this challenge. Notably, the presence of a supportive leader emerges as a critical factor in fostering compassion among staff, acting as a shield against the often unhelpful and critical pressures originating from macro-level governance and management. The study highlights the importance of cultivating a compassionate leadership approach. However, it goes beyond individual leadership and advocates for wider structural changes within the NHS. This entails the integration of compassion into policies, procedures, and practices throughout the healthcare system. The call for systemic change reflects a recognition that true transformation necessitates a comprehensive, organisation-wide commitment to embedding compassion at every level of healthcare delivery.