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## Practical compassions: repertoires of practice and compassion talk in acute mental healthcare

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**Abstract** This article reports an exploratory study of the concept of compassion in the work of 20 mental health practitioners in a UK Midlands facility. Using notions of practice derived from phenomenology and Bourdieusian sociology and notions of emotional labour we identify two contrasting interpretive repertoires in discussions of compassion. The first, the practical compassion repertoire, evokes the practical, physical and bodily aspects of compassion. It involves organising being with patients, playing games, anticipating disruption and taking them outside for cigarettes. Practitioners described being aware that these practical, bodily activities could lead to patients ‘opening up’, disclosing their interior concerns and enabling practical, compassionate mental health work to take place. In contrast, the second, organisational repertoire, concerns organisational constraints on compassionate practice. The shortage of staff, the record-keeping and internal processes of quality control were seen as time-greedy and apt to detract from contact with patients. The findings are discussed in relation to Bourdieu and Merleau-Ponty’s phenomenological accounts of practice and habit and set in context in the growing interest in placing compassion centrally in healthcare. We also explore how the exercise of compassion in the way our participants describe it can afford the more effective exercise of medical power.

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### Introduction

How can an attitude of ... compassionate concern be fostered and embodied in our culture? It obviously cannot be created merely through norms and rationalistic injunctions. It must be developed and embodied through disciplines that facilitate the letting-go of ... habits and enable compassion to become spontaneous and self-sustaining (Varela 1992: 73).

Recently, there has been a good deal of discussion of the desirability of compassion in healthcare. In the UK this has been highlighted by the Kings Fund in the UK (Kings Fund 2009), which underscored the value of good relationships between patients and staff in facilitating optimal care. Moreover, the British Medical Association (2011) has argued that compassion is

a key element of patient-centred care. The significance of the concept of compassion as a way of making sense of the best aspects of the healthcare process has animated recent reassertions of the centrality of compassion in healthcare relationships. For example, the recent Kings Fund initiatives have foregrounded the fundamental importance of compassion in the delivery of general nursing care, especially in acute hospital settings (Maben *et al.* 2009, NHS Confederation 2008, Smith 2008). In addition, a number of psychologists have argued for the development of 'compassion-focused' therapies, elevating the capacity to give and be receptive to compassion to a central place in the therapeutic process (Gilbert 2005, 2010). There is increasing evidence that this is therapeutically powerful and effective (Ashworth *et al.* 2011, Hofmann *et al.* 2011; Gale *et al.* 2012, Gilbert and Procter 2006, Laithwaite *et al.* 2009; Lucre and Corten, 2012).

In the sociology of health, too, notions of compassion are finding a place in the discussion of issues such as childbirth (Walsh 2010) suffering and justice (Williams 2008) and solidarity with the client (Rigoni 2007). Accordingly, the term merits some unpacking as its parameters overlap with those of other established sociological constructs such as emotional labour and emotion work, and, as well as being a purportedly mental disposition, compassion involves activity – it is a kind of practice. This latter practical aspect has hitherto been under explored. In addition, the operation of compassion in medicine is rendered complex as a result of long-standing concerns with medical power, both in sociology (Turner 1995) and in medicine itself (Canter 2001).

Consideration of the power that lies in the hands of healthcare practitioners is especially important as, despite the view that compassion is a desirable quality in healthcare, report after report points to lapses in compassionate care (Ballatt and Campling 2011). While the lack of compassion is often formulated as a personal or interpersonal failing, a key sociological insight is that healthcare – especially mental healthcare – can be seen as an exercise in power. In academic circles this has frequently taken its cue from Michel Foucault (1988) where authors argue that mental healthcare is a space for the surveillance and negative typification of disempowered individuals (Salzmann-Erikson and Erikson 2012). Despite recent interest in user participation there is a concern that the power structures have not been genuinely subverted (Bennetts *et al.* 2011). In the UK the Care Quality Commission (2013) has reported an increased use of compulsory powers in the mental healthcare system in recent years and observed that even patients who are voluntarily in residential care often have to cope with restrictions similar to those detained compulsorily. The existence of visitorial bodies such as the Mental Health Acts Commission and latterly the Care Quality Commission may do little to ameliorate the somewhat grim authoritarian quality of much residential care (Pilgrim 2011).

In the mental healthcare system compassion must perforce operate in an atmosphere shaped by the relative powers of the participants as practitioners or service users and inflected by broader patterns of disadvantage and legally backed control within which they are embedded. While reports on the future of the UK's National Health Service (NHS) foreground the value of compassion (Darzi 2008) this is often done with little grasp of the complex psychosocial, socio-political or practical aspects of the construct. Consequently, compassion is poorly researched in terms of its key qualities, facilitators and inhibitors in any particular area. The key challenge, then, is to think through what compassion means in the sociology of health and move beyond the kinds of definitions that posit it in personal or interpersonal terms, to discourse that instead enables it to be seen in terms that do justice to the institutional context in which it is exercised.

In recent years a great many professionals have come up with their own list of compassionate attributes and qualities. For example Lowenstein (2008: 12) sees compassion as being made up of empathy, respect, a recognition of the uniqueness of another individual, and the

willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and emotions of both the patient and the physician can be fully engaged.

A more concise definition is provided by Chochinov (2007: 184) using an approach whose origins can be traced to Buddhism, which states that compassion is 'a deep awareness of the suffering of another coupled with the wish to relieve it'.

Another popular way of approaching compassion is to try to understand it in terms of putative psychological mechanisms. For example, Gilbert (1989, 2005, 2010) sees compassion as being rooted in the evolution of caring, (Carter 1998) and affiliative behaviour (Depue and Morrone-Strupinsky 2005, Dunbar 2010). The caring behaviour that takes place between mammalian infants and parents has undergone radical transformations and today it is usual to care for our young, old, the sick and friends. In this view, an evolutionarily hard-wired predisposition toward caring is fundamental to our understanding of compassion. Gilbert (2009, 2010, Gilbert and Choden 2013) suggests that compassion has at least two psychological characteristics. The first is the ability to approach and engage with suffering. To do this we should first be motivated to do so and then be capable of paying attention to suffering, be able to be emotionally attuned to it, to tolerate any distress that arises, be capable of empathically understanding the nature and sources of the suffering and be non-judgemental about it. In this view, compassion is more than simply engaging with the experience of suffering. Hence, as Gilbert proposes, the second set of psychological characteristics is that of alleviation and prevention where we focus our attention on the practical matter of what will be helpful, which also involves being able to reason and work out what is helpful and behave in helpful ways with the appropriate feelings of warmth and kindness. As Spandler and Stickley (2011) add, compassion can help us develop a sense of purpose, meaning and hope. In the context of mental healthcare especially, it is these aspects that are believed to be vital to the process of recovery.

A further means of making sense of the issue of compassion is to see it in terms of emotional labour. From Hochschild's (1983) pioneering work on an airline cabin crew, the construct was rapidly deployed in nursing (James 1992). Since then debate has focused on whether there is indeed much room for emotional labour, in the fullest sense of the term, amid the frenetic round of duties that nurses undertake (Theodosius 2008: 5) or the extent to which emotional labour can be seen as a component in a broader labour process (Bolton 2009, Brook 2009). Hochschild's idea that members of the emotional proletariat had an inner core of identity over which could be layered various levels of acting has been supplanted by a more sociological sense that emotional labour is jointly achieved by the labourer and the recipient. This is evident, for example, in Theodosius's (2008) contention that emotional labour in nursing is a relational process in which nurses seek to help patients but the patient also helps to sustain the nurse.

At the same time, there have been some literary and sociological developments of the notion of compassion itself, for example, by Lauren Berlant, who characterises compassion in terms of 'individual and collective obligations to read a scene of distress not as a judgment against the distressed but as a claim on the spectator to become an ameliorative actor' (Berlant 2004: 1). In her view we should understand the concept as *an emotion in operation*. In operation, compassion is a term denoting privilege: the sufferer is *over there*. You, the compassionate one, have a resource that would alleviate someone else's suffering. (Berlant 2004: 4)

From a sociological point of view this helps illuminate how localised experiences of compassion can take place in a broader context of inequality or coercion. This interplay between coercion and compassion, and between interpersonal processes and institutional fields is one of the key enigmas in the social study of compassion, and something which we attempt to address in this article.

*Compassion and nursing*

For over 60 years scholars of nursing have identified the discipline as containing a strong strand of interpersonal work. Peplau's (1952) evolutionary theory of interpersonal relations between psychiatric nurses and their patient has become one of the fundamental tenets of the practice of today's mental health nurses. More recently Freshwater (2002) and Wright (2010) have argued for an appreciation of the value of the therapeutic relationship and the importance of what they call a 'therapeutic use of self' (2010: 154) which they see as integral to nursing and other caring professions. Bolton (2000) has described emotion work in nursing as a kind of gift from nurse to client. From the clients' point of view, too, there is a desire for treatment to involve developing relationships with nurses and other staff and one-to-one counselling, as well as informal opportunities for communication with knowledgeable and empathetic staff (Hopkins, Loeb, and Fick 2009). This contrasts with concerns on the part of official bodies that the time spent with in-patients in mental health may be of very limited value (Mental Health Acts Commission 2009). The political, economic and institutional framework within which care is exercised mean that in practice care will often be perfunctory, irrespective of the mind-set of the practitioners themselves. Indeed, in one case the Mental Health Acts Commission recorded that a single healthcare assistant was scheduled to make regular observations on 15 high-risk and vulnerable patients, such that she had only 25 seconds to locate and observe each patient (Mental Health Act Commission 2009: 222). The Care Quality Commission (2011) raises similar concerns about the paucity of opportunity for meaningful social interaction between staff and patients. Because caring behaviour can be costly of time while pressures exist for so-called efficiencies to do more and more with less and less, there is obviously a tension in these two different directions.

Equally, it is clear that nurses, who are strongly represented in our study, often start their professional careers with a compassionate desire to make a difference to patients' lives. For example, Maben *et al.* (2010) studied early career nurses over a period of time and found that they had high ideals when they were newly qualified, wishing to provide high-quality, patient-centred, holistic and evidence-based care. However, 2 years later many participants experienced frustration and showed evidence of burn-out as their ideals and values were thwarted. This led to disillusionment and job-hopping and in some cases they left the profession. Even in a single occupational setting, as Bolton (2001) notes, there is a complex process of emotional juggling to sustain survival in the organisation as well as a measure of engagement with patients.

Therefore, the question of compassionate care involves a degree of tension between several different factors. On the one hand, policymakers and profession leaders in healthcare stress the value of compassion, which is closely aligned with the interpersonal values espoused in the literature on nursing, the expectations of patients and the values of mental health practitioners. On the other hand, there are often organisational and practical constraints on how readily the prerequisites of compassionate care may be negotiated in practice, as witnessed by concerns from the Care Quality Commission and others. This means that the practical accomplishment of compassionate care presents a challenge to nurses and other health professionals in mental healthcare.

The view that nursing as a profession deeply imbued with practice and concerned with the practical accomplishment of caring is common to many accounts of the discipline (Rhynas 2005) and the question of how the cultures and practices of the profession can create contexts that have the potential to foster or impede health has prompted a good deal of scholarly reflection (Lynam *et al.* 2007, Morberg, *et al.* 2012). In making sense of the role of practice in nursing work, a number of scholars have turned to Pierre Bourdieu (1992, 1998) to conceptualise the distinctive features of healthcare work (Brown *et al.* 2008, Rhynas 2005). Bourdieu

uses the term *habitus* to draw attention to the often tacit features of culture and shows the ways it is embodied and lived. The term *habitus* refers to features of individuals, their outlook and the physical dispositions they deploy in navigating the social world. An example of this comes from Savage's (2003) examination of the embodiment of nurses' work, where it is clear that their *habitus* was both embodied and enduring but was also capable of changing or expanding to accommodate new contexts and surroundings. In Brown *et al.*'s (2008) study of infection control staff, there appeared to be a distinctive practice-based *habitus* of hygiene that was used to characterise their own working lives but also enabled them to distinguish themselves from other groups such as doctors. In this way their *habitus* and their construction of it could be used reflexively by the actors to position themselves in the social field. The practical aspects of mental healthcare work as they relate to compassion invite a comparison with Gilbert's 'second psychology' mentioned above – the practical matter of prevention, alleviation and helpful, compassionate caring work. It also recalls Berlant's (2004: 4) 'emotion in operation' and Theodosius's (2008) characterisation of emotional labour as relational, inasmuch as it calls into being a particular kind of relationship with another person, which that person's responses help to consolidate and sustain.

The role of embodied practice in healthcare work also has resonances with the work of Merleau-Ponty (1962), whose ideas informed Bourdieu's thinking. For Merleau-Ponty the primordial basis of philosophy is lived experience and (inter-)corporeal relationships. As embodied beings, practitioners in mental healthcare or any other context are both a part of the world and coextensive with it, constituting but also constituted (Merleau-Ponty 1962: 453). In this view, the body, practice and the phenomenal world are intimately related (Thomas 2005). Hitherto, many investigations of compassion in relation to healthcare have focused on the phenomenon as an attitude of mind – Gilbert's 'first psychology' – rather than a matter of practical activity or as Berlant puts it, (2004: 5) 'emotion in operation'.

Accordingly, the present study was conceived so as to examine practitioners' accounts of compassion in their daily work and explore how they formulated, interpreted and deployed the concept and its concomitant practices in the context of their working lives. In this way we hope to begin an exploration of how compassion is talked about as a practice, or emotion in operation.

## Method

A premise of our study is that language is used to construct accounts of the social world, accounts which are then used intentionally in attempts to make sense of the world, persuade and legitimise a particular world-view. In this view, as Potter (1996: 97) put it, language is a kind of 'construction yard'. Language may have material and social consequences and reflect patterns of contested power. At the same time, language is a site of contradiction and paradox and is a prime location for the study of social organisation. Furthermore, the 'use of stories to make sense of a situation or the world itself emphasises their role as part of the interpretive repertoire of culture' (Orr 1996: 12).

Our exploration of participants' talk about compassion therefore makes use of interpretive repertoires. Rather than the somewhat flat ontology of themes, this notion is useful because it directs us to explore the complexity of participants' accounts of their activities rather than seeing them as merely naive or socially ignorant. Put another way, talk is about doing things in the social world (Edwards and Potter 1992, Potter and Hepburn 2008).

The participants were 20 mental health practitioners working in an in-patient facility in the UK Midlands who agreed to be interviewed about the topic of compassion and its role in their

work. They included two consultant psychiatrists, two ward managers, two ward sisters, eight staff nurses, a final year nursing student and five healthcare assistants. The study benefitted from an ethical review by the relevant institutional and NHS ethics committees.

The interviews were conducted to elicit constructions of compassion, including questions about the meaning of compassion, the qualities of a compassionate person and the role of compassion in mental healthcare.

Once transcribed, the interview material was analysed by means of constructionist discourse analysis, which emphasises 'discourse as the vehicle through which the self and the world are articulated, and on the way different discourses enable different versions of selves and reality to be built' (Tuominen *et al.* 2002: 273). The approach assumes that 'the things we hold as facts are materially, rhetorically, and discursively crafted in institutionalised social practices' (Tuominen *et al.* 2002: 278).

Potter and Wetherell (1987) supposed that that people make use of language flexibly and resourcefully to construct morally accountable explanations of their actions. Analysis proceeds by attempting to identify the interpretative repertoires deployed by participants. These represent 'a lexicon or register of terms and metaphors drawn upon to characterise and evaluate actions and events' (1987: 138).

Accordingly, once they were transcribed and anonymised the participants' accounts were read repeatedly by the research team with a view to detecting ranges of accounts that contained similar 'relatively internally consistent, bounded language units ... called ... interpretative repertoires' (Wetherell and Potter 1988: 171). Discussion between team members and a comparison of their respective annotated transcripts provided the first stage in identifying the common ways in which the participants assembled accounts of compassion and its apparent benefits. As befits the discursive approach, in the forthcoming presentation we address how the formulations of compassion and one's responsibilities as a caring professional might, for example, justify actions, secure the speaker's identity as a worthwhile practitioner or assign blame elsewhere. Thus, rather than seeing the discourse as transparently reflecting the participants' motivation or thoughts and feelings, the interviews represent a conversational construction of their lives in relation to caring work, in which they are interested parties. Accordingly, analysis proceeded by identifying commonly occurring interpretive repertoires across the different interviews on the basis of initial impressions and annotations. The transcripts were then re-read and coded more formally to gain a picture of the prevalence of the emerging repertoire of interest and potential areas in which interpretive repertoires could be constructed. Areas of ambiguity were resolved through discussion among team members.

## Findings

In discussing compassion in their working lives, the participants drew on two key repertoires. The first of these, the practical compassion repertoire, focused on the practice of compassion through support, practice and meaning, whereas the second, the organisational repertoire, focused on a variety of contextual factors that reduced the availability of compassionate care for patients.

### *The practical compassion repertoire*

We have included in the practical compassion repertoire participants' accounts that attempted to define compassion and in which they described the exercise of practical compassionate care in their working lives. In response to questions from the interviewer all participants were able

to attempt a definition of compassion. What was notable was that there were distinctive practical elements in many of the definitions. For example the very first interviewee put it this way:

Interviewer: So I'm going to start by asking you what you understand compassion to mean?

Participant 1: Well, we deal with lots of people on the ward that, you know, have different traumas in their life, err, it can be a break up, it can be, err, you know, somebody with a mental illness, I mean, lots of err, mental illness, err, and we have to, you know, speak to them on an individual basis to find out what has caused or why, you know, they feel, you know, they're here. And also, that, err, to, to give them the support, erm, not just from us but from everybody on the ward, it's give some sort of support, and to be there and just to listen and, you know, to see if we can help them in any way, you know, to make their stay more, you know, well, I say, not more enjoyable but more pleasant because it's not a very pleasant experience being on the ward.

The notion of compassion is described here as a profoundly practical matter – 'dealing' with people, 'giving' support, 'helping' and ameliorating the experience of hospitalisation, akin to Berlant's notion of emotion in operation. At the same time, what is also noteworthy is that, in tandem with the practical matter of giving support, there is an indication that the patient's interior world is important to the definition of compassion, much as we might expect from existing research on the issue.

This practical theme in the concept of compassion prevailed when participants discussed their working lives, where the basis of compassionate care was formulated in terms of activities:

Interviewer: And what do you feel constitutes – uh – compassionate care?

Participant 2: It's seeing to all their needs, what they want and, and, just making sure in general they're alright, you know. Erm, like if they want to go out for a cigarette, just try your best to try and get them out 'cos that's what they want, 'cos all they can have, you know, one on the hour. It helps them a great deal, you know, otherwise things happen and you just think 'Do what you're supposed to do and take them out' and then you don't get anybody starting and banging and screaming and, because they look forward to that cigarette and now, you know, and if you can do it, do it, it helps.

Seeing to the needs and wants of patients is a part of compassion but also a matter of managing the hospital environment such that the inhabitants do not start 'banging and screaming'. The patients thus are characterised as being susceptible to a kind of management in relation to their needs and are apt to respond in a volatile manner if their putative needs remain unmet. As for Theodosius's (2008) participants, the emotional labour of compassion is not separate from the everyday practice of nursing but integral to it. This kind of interpretive work on the part of practitioners enables them to see clients in terms of needs that are actionable, in other words, that necessitate the activation of a particular kind of practice. Moving patients around, pre-empting the potential for disruptive behaviour, satisfying the longing for an anticipated cigarette – these are all actions in a practical repertoire that follow on from the participants' formulation of the patients' needs. Compared to, say, the models of clients' interior worlds that might be found in psychoanalytic psychotherapy, this formulation of the client might seem simplistic. However, the important point is that the formulation at stake here allows the hospital life-world to be something

that one can act upon and make manageable in particular ways, such that the likelihood of untoward incidents, florid displays of anger and related disruptions can be minimised. In that way the process is relational in that it invites a particular kind of compliant disposition on the part of the client and can be seen as both as something the practitioner can give the client – a gift (*qua* Bolton 2000) – and a reflection of the differing material powers of the practitioner and client (*qua* Berlant 2004). Moreover, as described here, it is preoccupied with interpersonal processes and activities at the expense of any questioning of the institutional or political contexts which constrain patients and place staff as their custodians.

The formulation of clients in terms of their incipient needs and as being emotionally labile appeared in a number of accounts of work on the wards:

Participant 6: The ward isn't too big. We've got a recreational room, you know, we've got table tennis, pool table, erm, and the Wii and the games console, but if you're a young male then you build up aggression, you know, it's just a way of getting rid of that aggression really, and erm, or diverting it into something else rather to anybody else or, or at us, really.

Clients then were seen as apt to suffer build-ups of tension that were best discharged, perhaps through activities such as pool or computer games. Again, what might seem a somewhat simplistic model of clients' inner life is nevertheless finely attuned to the services and facilities available and allows the practitioner to act on the situation to avert potential adverse events resulting from 'aggression' and instead invite compliance. This conceptualisation of clients in terms of their putative needs resonates with broader coercive trends in health and social policy (Brown and Baker 2012). Participants' commitment to addressing clients' needs through their professional practice sometimes extended to more formally organised games. This commitment to activities as a means of exercising compassion appeared in many participants' accounts as one said:

Participant 4: Each ward is doing, erm, like a night probably once a month, once every six weeks, where we compete against each ward. And the very first one that came up, and I did it, and we did a tournament for tennis, table tennis, and, er, you'll be surprised how many people came, and they came up. We won it, that, actually, we won it for our ward. But it's just trying to make them, keep them busy and do things with them, you know, 'cos – I don't know about you – but you don't see them get many visitors do you?

The organisation of games, sports and social activities is formulated as a compassionate process of addressing a perceived absence in the patients' lives – discharging aggression, providing social contact or even the transient pleasure of a cigarette. The lack of sustained social networks for the patients directs the practice of compassion towards generating social interest, providing social and sports events and facilitating interaction. What Bourdieu (1980) called the *sens pratique* – the practical orientation – directs them towards substituting a version of social life for the otherwise apparently isolated and directionless life of the patients. This sense of themselves as having what Bourdieu might term an 'action schema' (in contrast to the patients), reinforces what we have mentioned earlier as compassion involving both a hierarchy and a gift. Moreover, it is one that elicits a particular kind of participation on the patients' part.

This analogy with the relational aspect of emotional labour was particularly apparent where the participants discussed the patients' inner psychic life. Interaction through games and sport was said to facilitate a more explicitly psychological process of opening up:



Participant 9: Support to the patients ... which we try and do in meeting on their level, even if it's just having a game of cards or a game of pool with them or just a little walk or, so you never know 'cos when people are going to open up to you.

The opening up process, when it had occurred via games or social activity, enables access to a kind of interior workspace where the therapeutic project can gain some purchase:

Participant 12: If I know a patient's got a problem and they're sat with some of their peers in a group I try and sit with them and listen to them open up with the group and then try and get them on a one to one basis and discuss that.

As Vitellone (2011) reminds us, compassion often involves doing something to someone – often a person in a privileged position (in this case a health professional) performing some kind of interpersonal labour on the marginalised, the vulnerable or the dispossessed. Practical compassion here is about creating the circumstances in which participants can open up, certainly, but it is also about actioning the normative expectation that patients in a mental health setting can and should engage in self-disclosure. The activities and games are presented as a way into this. In this respect, it is akin to what Miller and Rose (1994: 31) call the 'orthopaedics of the soul' such that therapeutic theory and practice subject the patient to a kind of authority and potential rectification. Thinking about clients in terms of feelings and needs unfolds the spaces into which their distress and disability can be worked upon through the emotional labour of the practitioner, their thoughts and feelings can be ventilated and reconfigured and the unintelligible manifestations of mental ill health – the potential for 'banging and screaming' mentioned by Participant 2 – can be defused.

In similar vein, the practice of compassion could just as easily be formulated in a more egalitarian fashion:

Participant 9: If you could hold back a little bit and see what's helped in the past and stuff, it'd be more, like, to be more of a companion really on a journey as I said before than a, you know, to facilitate that journey really, 'cos they've more expertise than we are, whereas we like to see ourselves as the experts a lot of the time.

Here, the account is formulated in terms of mutuality, a sense of treating others as you would wish to be treated and a sense that the patients have some expertise of their own. In this quote also we can see allusions to a more humane rendering of the 'patient journey' – a phrase now common to many new understandings of patients' experience of long-term illness (NHS Institute for Innovation and Improvement 2008). This humanitarian orientation extended to some accounts where practitioners described themselves as making the hospital processes, professional vocabularies and routines more intelligible to the patients, a process which we might call translational compassion:

Participant 1: Because if you bombard somebody with all these questions and all things that you, erm, how can I put it? I put it in layman's terms, me personally, because a lot of the patients come here, they don't understand, erm, all the terminology that we use. So if you put it in laymen terms, you know, they understand it better.

Interviewer: Absolutely.

Participant 1: You know, I treat them how I want to be treated.

Common to all these characterisations of compassion was the notion of doing things for and to the people in the participants' care – a mode of compassion intimately connected with the *sens pratique* and with a kind of practice-based habitus of caring work. Moving people around, pre-empting untoward incidents, supporting, making hospitalisation tolerable and organising social and sports events all operate at the level of material bodily practice or habitus. In addition, this practical compassion repertoire included the segue from physicality to mentality. That is, through the physical activity of games, groupwork or going for a walk with a patient, an interior mental space could be brought to visibility into which the panoply of compassionate operations could be extended, and in which the internal emotional choreography of the patient becomes actionable and manageable. In this way it could be claimed, with Theodosius (2008), that the emotional labour of practical compassion is integrated into mental healthcare and is not a readily separable feature of it. It is a conjoint therapeutic effort involving practitioner and patient in a relationship; it is interactive and relational such that the compassion is offered and the patient opens up to therapeutic reconnaissance and action.

### *The organisational repertoire*

In the previous repertoire the participants did a great deal to explain to the interviewer the role of the practitioner in relation to the patient and elaborated a version of compassion as a kind of practice. There then arises the issue of why this ideal might not always be achieved in practice, and how the concerns over perfunctory treatment and neglect mentioned in the introduction come to occur. This has important parallels with Mulkey and Gilbert's (1982) work on how scientists account for 'error', or the failure of different researchers to agree. Scientists described themselves as scrupulously following facts whereas others, who gained different results, were hidebound or committed to outmoded theories, among other things. Similarly, participants in the present study undertook considerable interpretive work to explain why they could not be as fully committed to compassionate work with patients as they would like to be.

First, and most frequently mentioned, was the physical availability of sufficient staff to provide the level of care necessary for compassionate practice:

Interviewer: So what are the issues you feel that prevent you giving your patients the high-quality compassionate care you'd like them to have?

Participant 14: Staffing levels. It'd be grand if we could have more staffing levels, more staff ratio to patients so we can be able to have that time with the patients. Erm, and at the moment we are looking at a productive ward, which is supposed to be enabling us to have more time with the patients, so just things like that really, more staffing levels, more facilities.

The control of resources to enable compassionate practice, then, was construed as being outside the practitioners' remit, a position found also in Ackroyd and Bolton (1999). A further factor that was identified by the participants as imposing limits on their ability to interact with patients was what they termed paperwork, which was felt to represent an incursion into their time with patients:

Interviewer: What about, um, time, do you feel you have enough time?

Participant 13: I feel there's far too much paperwork. Erm, obviously when we have a conversation with someone we've got to write it down. Erm, quite a lot of it's repetitive. Erm, for example, we're constantly repeating ourselves when

we're going through the admission process, erm, that, I don't think, isn't very fair on the patient either.

As in the quotation from participant 13 above, this included recordkeeping on the patients' admission and progress, which was seen to be repetitive and antithetical to the practical, compassionate support of patients. In quotations like this it was as if the paperwork – although much of it would in practice be done via computers – was distinct from, and reduced the resources available to the key business of compassionate caring work. This underscored the point made in the practical compassion repertoire; that compassion is about practical work rather than recordkeeping or documentation issues. The same was said to be true of a variety of tasks relating to the organisation itself, its internal monitoring and quality control activity. This too was paperwork and was said to be incommensurate with patient care:

Participant 19: The amount of paperwork is just ridiculous and there's more tick lists and things, like audit tools and stuff that are coming through, and I know it's very important for audits to take place but it just increases the workload on the ward and if somebody's sat in an office ticking boxes they're not sat outside with patients interacting.

The monitoring of quality was therefore incompatible with the face to face activities of caring work with patients. Indeed, the documentation of care and the paperwork was seen as an activity that had the capacity to absorb increased staff resources:

Participant 10: But then I'd be left to wonder if there was more staff on the ward would they just be doing more care plans and more paperwork rather than [actually doing], so maybe it's not, maybe it's not about the number of staff on the ward, maybe it's about what the staff should actually be doing, erm, and changing the culture of how we work.

The organisational repertoire was therefore important in explaining how face to face care could be less compassionate than might be considered ideal. The lack of staff resources and the expansive properties of paperwork reduced the opportunities for compassionate practice and for its associated emotional labour. Like some of Theodosius's (2008) participants, they decried the restricted opportunities for this kind of work, which was seen as more valuable than the paperwork.

## Discussion and conclusion

With this small sample of UK Midlands practitioners, we have gathered some clues as to how discussions around compassion are framed by mental health professionals in a climate where patient care is often surrounded by limitations in resources and a good deal of defensive administrative work.

One of the key findings is the relationship the participants carved out between compassion and practical work. The embeddedness of compassion in practice, with the arrangement and hexis (or state) of bodies, the involvement with games, sports, social events or even companionable walking around, invites us to revisit the comparison made earlier with the work of Maurice Merleau-Ponty (1962). In mental health practice, according to our participants, compassion is seen as more than an attitude of mind; instead it is intensely practical, for it is by acting upon the social milieu of the clinic that practitioners were able – in their terms – to exercise compassion. According to Merleau-Ponty, sensing and perceiving in practice is an

active part of conduct accomplished by integrating one's own and others' bodies' postural schemas in orientation, movement and the rhythms of clinical life. To extend Merleau-Ponty's account, what the practitioners live through, with their 'operative intentionality', precedes and informs their sense of personal knowledge (Merleau-Ponty 1962: 137, 173). Living and working through the practice of compassionate care gives practitioners their sense of what compassion is all about. In Merleau-Ponty's view of phenomenology, our primary relation to our environment consists of performative and mediating competence, in this case, compassionate work with clients.

Compassionate practice is not constructed from the beginning in every encounter. The regularities of practice become embedded into relatively stable patterns of behaviour and sedimented meanings consisting of past layers of experience (Merleau-Ponty 1964: 89). These habits enable a degree of spontaneous improvisation yet maintain the permanence needed for continued and sustained practice over time. For Merleau-Ponty, therefore, habits are acquired and socialised skills, gestures and techniques emerge from a social habitus, which rearrange and renew the corporeal schema (Merleau-Ponty 1962: 142). In this view, habits are routinised practices which immediately inform us of what is going on in practical situations before we reflect on them: 'Habit expresses our power of dilating our being-in-the-world or changing our existence by appropriating fresh instruments' (Merleau-Ponty 1962: 143). In knowing whether clients are about to open up or in anticipating and heading off disruptive behaviour, the participants described themselves engaging in a 'situated responsiveness', which itself is a 'specific answering practice' (Waldenfels 2007: 54). The practical understanding of oneself as a compassionate carer is based on this experience of oneself, others and the phenomenal world and, as part of this *sens pratique*, the immanent likelihood that it will call up particular patterns of behaviour on the part of patients, who will be more likely to refrain from disruptive behaviour and instead open up to therapeutic scrutiny.

It is also noteworthy that in contrast to the bodily, corporeal and emotional aspects of the practical compassion repertoire, the organisational repertoire evoked something altogether more cerebral and literate and was considered to be less valuable. Patient work involved moving people around, being with them, playing with them and organising the social life of the clinic. The organisational repertoire by contrast evokes writing, thinking, form-filling, responding to requests for audit information and external quality assurance. The practical compassion repertoire is inwardly directed towards the life of the ward and the patients' interior worlds, whereas the organisational repertoire alludes to external issues such as resource constraints, demands for documentation, audits and quality assurance. The value attached to the practical, compassionate emotional labour of care chimes in with what was found by Theodosius (2008) and Brown and Crawford's (2003: 71) practitioners who saw it as their job to be 'on the patch with clients'.

The distinctiveness of the way these practitioners talked about compassion in their work becomes more apparent if we contrast this with the notion of compassion in the more psychologically minded formulation of the concept in the literature cited in the introduction (Gilbert 2009). This latter view of the issue is informed by Buddhism, seeing compassion emerging through a process of learning about one's own mind, being reflective and deploying this as the basis for empathic connection. By contrast, for the clinicians quoted here, compassion was not about personal reflection, personal work or relating compassion for others to self-compassion. The interviewees saw the limits on compassion as being organisational in nature and there was no reflection about the potential for compassion burn-out, how that might happen and how individuals might protect themselves against it. Compassion was not discussed in terms of internal motivational processes that guide actions and feelings but rather as 'something done to' another with a view to reducing destructive behaviour or trying to make the day more

pleasant. As described by the participants here, compassion has more in common with Gilbert's (2009, 2010) second psychology of alleviation and prevention.

The valorisation of practical aspects of compassion by the participants invites some reflection on recent debates about values in healthcare practice, too. For example, a focus on ethics rather than technologies in mental health care has been urged as part of a post psychiatric approach to care (Bracken and Thomas 2001). A more explicit appreciation of values in mental healthcare has been recommended, for instance, by Williams and Fulford (2007) who highlight the need to juggle complex and sometimes conflicting values and points of view effectively. In this framework the intimations of participants of how they attempt to foster egalitarian relationships and their framing of compassionate work in terms of acting as a guide through abstruse and confusing systems might be welcomed. Yet at the same time, the taken-for-grantedness of mental healthcare can serve to expand the power inherent in mental healthcare (Bradley and Carter 2011). Therefore it is important to consider what the construct of compassion, as it is understood in the psychotherapeutic disciplines and in the accounts of practitioners presented here, leaves unsaid, and the kinds of world views to which it predisposes. Compassion orientated to clients' futures, according to Lee Edelman (2004) is always conservative. At the heart of Edelman's critique of compassion is what he sees as its logic of reproductive futurism that compels the spectator or practitioner to feel for the client. In similar vein, Berlant (1997: 4) argues that compassion turns 'the political public sphere' into 'an intimate public sphere'. This intimacy can distract us from critical, political engagement with suffering and makes the broader impress of power more difficult to think about, as well as reinforcing institutional boundaries and medico-political inequalities. For Bourdieu, the dispositional practices of everyday life are intimately tied in with the processes of symbolic power and domination.

The role of compassion in our ways of talking about contemporary healthcare systems is increasing in both practice and policy. It is a construct that has been deployed in making sense of patient satisfaction (Heffernan *et al.* 2010), a focus for therapy (Gilbert 2010), safeguarding patients from abuse (Care Quality Commission 2011), emotional self-management (Neff *et al.* 2008) solidarity with marginalised and oppressed people (Rigoni 2007) and enhancing education for future healthcare professionals (Shield *et al.* 2011). In sociology, accounts of social justice have also emphasised compassion (Williams 2008), as have exhortations towards improving healthcare (Walsh 2010). It is claimed that through the actions of compassion practitioners can become more fully geared towards understanding patients than implementing procedures (Sieger *et al.* 2012). Seeing these aspects of caring work as manifestations of a *sens pratique*, with an associated professional habitus and a place within broader patterns of domination, offers a way to think about the flexibility and resourcefulness of caring work.

This article has pointed to a number of critical issues that are of importance for a sociological understanding of the concept and how it may be exercised. As with Brook's (2009) account of the emotional labour process, compassion may perhaps be understood as a kind of labour process and as one allied with Bourdieu's *sens pratique* and habitus. As described by the participants here, it is not so much like acting, as in Hochschild's (1983) original formulation, but more like a meticulously flexible workplace craft skill that can be applied to manage the emotional climate of mental healthcare. Consonant with accounts of mental healthcare that have emphasised coercion and control, the compassion talk of our participants identifies patients as potentially problematic and offers means of rendering them more manageable and predictable. While psychological accounts have emphasised the interior workings of the person exercising compassion, the participants have highlighted here how their interventions – 'practical compassions' – have opened up the patients to clinical scrutiny and interior management. Compassion, then, shapes and is shaped by conditions of inequality and coercion and, by

means of its focus on interpersonal processes, deflects attention away from the institutional and legal constraints that are applied to patients. Perhaps, as participant 10 said, developing a more fully compassionate mode of care is primarily about changing the culture of how mental health work itself is done.

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