

The Language of Compassion in Acute Mental Health Care

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Abstract

In this article we examine the language of compassion in acute mental health care in the United Kingdom. Compassion is commonly defined as being sensitive to the suffering of others and showing a commitment to relieve it, yet we know little about how this is demonstrated in health professional language and how it is situated in the context of acute mental health care services. We report on a corpus-assisted discourse analysis of 20 acute mental health practitioner interview narratives about compassion and find a striking depletion in the use of “compassionate mentality” words, despite the topic focus. The language used by these practitioners placed more emphasis on time pressures, care processes, and organizational tensions in a way that might compromise best practice and point to the emergence of a “production-line mentality.”

Keywords

discourse analysis, emotions / emotion work, health care professionals, language / linguistics, mental health and illness

There is a need to investigate the language of compassion, given raised concerns about a lack of compassionate care in modern health care (e.g., Care Quality Commission, 2011; Crawford, 2011; Darzi, 2008; Firth-Cozens & Cornwell, 2012; Gilbert, 2009; Nauert, 2011; Parliamentary and Health Service Ombudsman, 2011; Shields & Wilkins, 2006) and the prominent role of language in accounting for, promoting, and transforming particular visions of care. This is a priority in acute mental health, where poor standards of care have been noted in various reports (e.g., Department of Health, 2002; Muijen, 2002; Norton, 2004; Rethink, 2004; Sainsbury Centre for Mental Health, 1998). In this article we examine the language of compassion in interview narratives of acute mental health care practitioners in the context of the demands and perhaps threats of a production-line approach to care delivery. The latter is particularly important, as we know that cultures of threat can be a major barrier to the development of compassionate mentalities among practitioners, and lead to compassion fatigue (Rothschild, 2006). The language used by practitioners in discussing compassion should provide a useful insight into this dynamic.

The National Health Service in the United Kingdom has changed radically in its focus over recent years. Its psychological core of caring and cooperating for the health of the nation has shifted to a focus on management (nonclinical) bureaucracies aimed at “driving efficiencies” and “target-led cultures,” with the belief that a

competitive, business-focused ethos will somehow create a better environment for care (Lister, 2008). In fact, it is clear from many recent reports that exactly the opposite is occurring (Leys & Player, 2011). Seddon (2008) suggested that when systems are under stress and driven by targets, they generate “threat stress” and encourage leaders to coerce subordinates. As he pointed out, one of the key problems is that organizations become focused only on outputs and not on process, inputs, or actually understanding the demands on the service and how to meet these.

Outputs-focused accountancy and seeking efficiencies—doing more for less—often develop at the expense of compassion because compassion by its nature is relatively time intensive, requiring that staff pay attention, listen, and relate. To do this, practitioners need to be in the psychological state of compassionate mentality rather than being subject to a state of stress, anxiety, and constantly working against the clock. If we genuinely wish to create compassionate care we need to pay particular attention to the social context of care delivery.

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Modern iterations of instrumental and target-driven health care might actually be creating conditions that inhibit rather than promote compassion-based psychologies. In other words, the current climate in which health care is planned, developed, and implemented are pulling on different and rather restricted mentalities, and might make compassionate mentalities in providers more difficult to secure.

Compassion is a complex, multifaceted psychological and social process (Gilbert, 2009). Compassion can be defined as “a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with a wish and effort to relieve it” (Gilbert, p. xiii). However, it is a complex, multifaceted psychological and social process that integrates a number of different attributes of mind. For example, from a Buddhist tradition, Feldman and Kuyken (2011) suggested that

[c]ompassion is a multi-textured response to pain, sorrow and anguish. It includes kindness, empathy, generosity and acceptance. The strands of courage, tolerance, equanimity are equally woven into the cloth of compassion. Above all compassion is the capacity to open to the reality of suffering and to aspire to its healing. (p. 143)

Based on the common definition of compassion, Gilbert (2009) identified two very different psychologies associated with compassion. One is focused on engagement and understanding, and the other is focused on alleviation and relieving. In regard to the ability to engage with suffering, this requires the motivation to do so with abilities to attend to it; emotionally engage with it; tolerate the distress of the other and self; have some empathic understanding of the source and nature of suffering; and be nonjudgmental or uncondemning. The second psychology of alleviation is how we seek to alleviate distress and suffering by being aware of and practicing appropriate ways of thinking, feeling, and behaving. These mutually influence each other. Gilbert referred to compassion as a social mentality because it integrates motivation, thinking, feeling, and behavior in specific ways to achieve specific goals.

One of the ways in which we organize our minds and in particular the various mentalities that are possible to us (such as competitive, cooperative, compassionate, hostile) is via the shared values and language that shape discourse and thinking. Although a number of recent health publications have highlighted the importance of compassion within health care (e.g., Ballat & Campling, 2011), little research has been conducted on (a) practitioner perspectives on compassion in health care generally, or specifically in acute mental health; (b) the language of compassion; or (c) how practitioner language is situated in the context of threat stress. This is despite a growing

focus on health communication and language (see Brown, Crawford, & Carter, 2006).

Our research questions were as follows: What is the language of compassion used by acute mental health practitioners? In what ways might threat stress be influencing their language choices? If, as social constructionists might argue, health care language sets the track for practice, then this investigation might consolidate and advance compassionate discourse among policymakers, organizations, managers, and clinicians.

Method

Practitioners in two acute mental health units at a mental health National Health Service (NHS) trust in the United Kingdom were invited to take part in an interview to explore their perspectives on compassion. Before starting the research, ethical approval was obtained from the clinical research committee for the clinical site and the relevant National Research Ethics Service committee. A participant information sheet was provided outlining the study, protection of confidentiality, and the right to withdraw all information provided at interview within a 4-week cooling-off period.

In total, 20 practitioners were interviewed, including 2 consultant psychiatrists, 2 ward managers, 2 ward sisters, 8 staff nurses, 1 third-year student nurse, and 5 health care assistants. Acute mental health units were chosen because of raised concerns in the United Kingdom about the quality of care standards in these areas. The units predominantly treated people experiencing acute symptoms of schizophrenia, bipolar disorder, and severe depression.

Interview Procedure

All interviews were conducted by the same interviewer (Jean Gilbert) using a standardized, semistructured format. The participants were questioned about the meaning of compassion, the qualities of a compassionate person, and the role of compassion in mental health care (see Appendix 1 for the interview schedule used). Interviews lasted between 20 and 30 minutes. Audio recordings were completed digitally, transferred onto a secure NHS network, and erased from the recorder. The transcribing was undertaken by a member of the research team. All written documentation, including consent forms, was stored securely in locked filing cabinets within the mental health research unit at the clinical site. All participants were assigned a pseudonym during the preparation of transcripts and only members of the research team had access to the participants' contact details. All data will be kept for 7 years in locked filing cabinets prior to being destroyed.

Analysis

In this study we adopted a mixed qualitative and quantitative design, using corpus-assisted discourse analysis (Partington, Morley, & Haarman, 2003) to examine the language of compassion in the interview narratives of personnel from the two acute psychiatric units. This approach has been tried and tested (see, for example, Adolphs, Brown, Carter, Crawford, & Sahota, 2004; Brown & Crawford, 2009; Crawford, Brown, Nerlich, & Kotevko, 2008; Harvey et al., 2008). Computational analysis of language uses special computer software, in this case AntConc 3.2.4w (Anthony, 2011), which enabled us to identify frequently occurring words and phrases in data. The software generated ranked word frequency lists for large or small bodies of text (corpora).

Frequency lists offer an overview of the number of times any word is used in any given text (corpus) relative to other words. The software can also present all occurrences of any key or important word in the text and the language occurring before and after it (concordance). Here, we can see the context in which words are used. Word frequency lists and concordances can be used as a diagnostic tool (Adolphs et al., 2004) to achieve a baseline for determining what the text is about, its patterns and regularities of meaning or semantic prosody (Louw, 1993; Sinclair, 1991), and can underpin and support claims of discourse analysis.

The transcripts of the 20 interviews were edited to remove interviewer questions before being converted into a text file (32,556 words) that we called the Acute Mental Health Practitioner (AMHP) Corpus. Generating this corpus and reviewing word frequency and concordance lines using AntConc 3.2.4w software (Anthony, 2011), we were able to capture what this kind of talk comprised in terms of its main concerns. Building on the insights afforded from this textual diagnosis, we interpreted the full transcripts using a constructionist discourse analysis (Tuominen, Talja, & Savolainen, 2002), viewing the practitioners' language as a social practice articulating a version of themselves and their clinical world.

Our analysis involved examining the words and phrases used by practitioners in response to interview questions about compassion and the ways these choices amounted to a particular construction or characterization of clinical events and their own stances and actions. In particular, we investigated the lexical variants¹ of the listed attributes or characteristics of a compassionate mentality derived from various models of compassion, as follows: kind, gentle, warm, loving, affectionate, caring, sensitive, helpful, considerate, sympathetic, comforting, reassuring, calming, open, concerned, empathic, friendly, tolerant, patient, supportive, encouraging,

nonjudgmental, understanding, giving, soothing, validating, respectful, attentive.

Using the textual diagnosis as a guide to salient language, the transcriptions were read several times and annotated by the research team to identify patterns and common features of discourse, and to determine how compassion featured in practitioner constructions. Perspectives on the discourse were then shared between team members. The research team comprised three psychologists, a registered mental health nurse with expertise in applied linguistics in health care, and an applied linguist with a research profile in health discourse analysis.

Results and Discussion

In this study we determined the level of compassionate mentality conveyed in the body of purposefully elicited practitioner talk and considered this in the context of threat stress resulting from target-led health care. By combining the frequencies of lexical variants of attributes or characteristics of a compassionate mentality, we achieved a fairly robust sense of what did and did not feature in practitioner conceptualizations (see Table 1). On analyzing the combined participant language used in this corpus, we identified a number of unexpected patterns.

First, there was a marked depletion in language related to attributes of a compassionate mentality. Second, language use concerning paperwork, processing, and time, connoting a production-line mentality, intruded substantially into practitioner constructions. Third, the language indicated an institutional mentality and emotional distancing between practitioners and patients. These patterns are described below, accompanied by excerpts or concordance lines from the corpus.

Compassionate Language Depletion

The most prominent of 28 attributes of a compassionate mentality in the interview transcripts were: caring, helpful, giving, supportive, and understanding. These occurrences were modest within the corpus as a whole and we were able to identify only 218 lexical variants for all attributes; that is, 0.67% of total language used. This shows a marked depletion in language relevant to a compassionate mentality. Indeed, the mean frequency of such words used by participants was 10.95, suggesting only minimal evidence of compassionate language in this corpus. This is even more astonishing given the topic focus of the interviews.

Of course, expressions of compassion and caring can be realized through lexical means other than the central vocabulary items listed in Table 1. That being said, the

Table 1. Lexical Frequency of Compassionate Mentality Words in the Acute Mental Health Practitioner Corpus.

Attribute	Frequency (n) of Lexical Variants	Total Frequency	Attribute	Frequency (n) of Lexical Variants	Total Frequency
Kind	kind (7); kindness (1)	8	Concerned	n/a	0
Gentle	gentle (2); gently (4)	6	Empathic	empathy (10); empathetic (2)	12
Warm	warm (1); warmth (1)	2	Friendly	friends (1); friendly (1)	2
Loving	love (1)	1	Tolerant	n/a	0
Affectionate	n/a	0	Patient	patience (1); patient (1)	2
Caring	care (19); caring (28); cared (1)	48	Supportive	support (20); supported (2); supportive (3)	25
Sensitive	sensitive (1)	1	Encouraging	encourage (1); encouragement (1)	2
Helpful	help (24); helping (4); helpful (5)	33	Nonjudgmental	nonjudgmental (4)	4
Considerate	considerate (1)	1	Understanding	understand (7); understanding (12); understandable (1)	20
Sympathetic	n/a	0	Giving	give (20); giving (11)	31
Comforting	comforting (1); comfortable (3)	4	Soothing	n/a	0
Reassuring	n/a	0	Validating	n/a	0
Calming	n/a	0	Respectful	respect (3); respected (1); respecting (1)	5
Open	open (9); opened (1); opening (1)	11	Attentive	n/a	0

Note. The corpus comprised 32,556 words.

absence of such a fundamental lexis (total bank of words and phrases) of compassion is telling, and even when compassionate terminology appeared in the participants' discourse it was commonly divorced from any affective usage. For instance, if we consider the term *care*, one of the lexical variants of the most prominent attribute of caring ($n = 48$), we can see from the sample concordance line fragments in Figure 1 that it is more to do with a process, a product, or a system—that is, the work of hospitals—as it is the description of anything concerning positive emotional or affective engagement with the patients. It is about delivering a repertoire of actions or interventions which might or might not be up to standard. Out of 90 instances of *care*, only 19 aligned clearly with compassionate commitment to the service user—something better captured by sample concordance lines for *caring* ($n = 28$; see Figure 2).

Paperwork, Processing, and Time

The general paucity of compassionate language bears out an emphasis on working against the clock and delivering process-focused as opposed to person-focused care. A simple word list for this corpus has lexical items salient to the idea of compassion ranked lower than *paperwork* (127): *help* (152), and *understanding* (166). In addition, even the word *understand* in the sample concordance lines for *understand* and *understanding* (see Figure 3), is

used as a kind of explanation or mitigation for problematic behavior on the part of clients (“I can really understand why they get fed up”), or indicates comprehension both ways, from professional to others and from others to the professional.

The word *need* appeared to have been used in a bureaucratic or actuarial sense; that is, in terms of assessing a need so as to activate the provision of care if it was more severe than a predetermined score. It was just what things were called in the system. As with the word *care*, *need* does not signal empathy; putting oneself in another's position; or imagining another's point of view, plans, policies, or desires. The low prominence given to human interaction was even clearer with the following low-ranked words concerned with interaction: *talk* (165), *talk-ing* (895), *speak* (399), *speaking* (716), *listen* (341), *listening* (390), *communicate* (766), *communication* (484), *communicating* (1436), *communications* (1437). In the sample concordance lines for *give* and *giving* (see Figure 4), we can see how the desire to give compassionately appears to be compromised by a culture of threat, where time and a busy health care environment determine behavior.

It is noteworthy that a number of the mentions of *giving* were to do with what practitioners cannot give: time, a better service, and the like. There was also a kind of moral imperative in some cases: “We can't give the service we should be giving.” So they had a sense of what

sabotages the, the, the sort of quality of **care** in my opinion. Erm, so the / in the sense of erm, providing day to day **care** to acute inpatients, erm, / the admin work does stop me providing **care** to the patient because patient / providing **care** to the patient because patient **care** takes dominance over the / fulfilled I would not be able to deploy good **care** to the patients. Yes, I, I think / over-crowdedness, to be able to provide more **care** to the patient and more / within. Yes, I think quality of, err, quality of **care** comes from really more time / community might be

Figure 1. Sample concordance lines for “care.”

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Figure 2. Sample concordance lines for “caring.”

what you mean? Erm, just, mm, just **understanding** how they are. I mean like / is that compassion? I don't know. Being **understanding** and having a bit of heart / a lot more harder. Erm, I'm a very **understanding** person anyway, erm. I raised / residents wise. I wish they'd be a bit more **understanding** towards me, you know / I must admit they don't, you know, they **understand** about me as well. I don't / in the morning. So, yeah, so you can **understand** why they have a cigarette / Erm, compassion is trying to **understand** things from an individual's perspective, / are very abusive regardless of, and I can **understand** it to an extent when they're / And they get fed up and I can really **understand** why they get fed up. I could not be

Figure 3. Sample concordance lines for “understand” and “understanding.”

they should have been doing, but could not. That being said, the concept of *should*, like ought or must, in contrast to want, wish, or desire to, indicates an authoritarian way of thinking of meeting the standard. It perhaps resembles what in cognitive therapy is sometimes called the “tyranny of the should.” This kind of fix must have been rather demoralizing for them. There is a conflation of

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 / how I feel, you know, and I wished I could **give** more, and I can't, you know. Well, / going on the ward. So now we can't even **give** them the patients protected time. / it hard sometimes. No it isn't, no. but to **give** them a hug, to **give** them whatever is, / I haven't got, got time, as much as I'd like to **give**, because I've got to go and do / yeah I do, and sometimes I think I wish I could **give** more but I haven't got the time. / we can't **give** the service that we should be **giving** because everybody is so rushed / on. Compassion to me, it means **giving** the best of what I've got to somebody

Figure 4. Sample concordance lines for “give” and “giving.”

giving and quality in the last line: “it means giving the best.” In addition, such a context was evidenced with frequent references to time ($n = 262$), often in the context of it being a pressure, threat, limiting factor, or frustrating lack which hindered delivery of care. In fact, *time* was ranked 24th (very high) in the word frequency list for the corpus.

The term *support* was largely used in two ways: showing, offering, or giving support to service users, or getting support from colleagues and management. In terms of the latter, most respondents noted the lack of support in busy environments, and linked this to failing care and compassion depletion:

We're working from the bottom up. Erm, a lot of good work takes place. It, it is atrocious in some ways, the lack of care, the lack of, the lack of, er, support, the lack of therapy that's available, but a lot of work is being done.

You know, you get home, you think, “I didn't do this, I didn't document this, didn't document that.” You know, it's gets, more, more support, more support, and more of a drive to make the hospital experience more of a compassionate one.

The staff, er, that's just from the patient's perspective. The staff are often extremely busy with very varying demands, and perhaps my own view would be they are not adequately supported to think about and to, so they haven't got the protection and the, the space in which to, er, to do more than what they're doing.

The words *help* and *helpful* in the corpus referred to things that assisted in the delivery of care as much as demonstrated a compassionate mentality. Frequently, practitioners referred either to how the environment, time pressures, and so forth did not help care delivery, or to the kind of resources (such as time) that would have proved helpful:

So I think sometimes when things are very, very busy, I think that doesn't help people to, you know, cos I think people don't have the time to think about what they're saying to people, and how they're saying things, and things like that, and that can be a problem. I don't feel that environments, erm, is helpful at, at all. Erm, and like I say, it's restricted, it's always time restricted because while you're even having a conversation with somebody you're thinking, "I've got this to do and I've got that to do." Yeah, I know, I'm trying to give them my full attention but, you know, there are other things, erm, on your list that, that are there, you know, in the background.

The threat stress in the latter excerpt is even more palpable in the following account of the help needed to counter a production-line mentality that hindered a "more caring environment":

The charge nurse was in to control the ward; no one got to their staff. She could be horrendous. She could be very supportive, but she created a safe environment, a, a, when it was, when it was working properly, erm, and delivered, and looked after her staff. I think that model, though it's no longer possible, would help create a supportive environment for the staff. They are very concerned about safety, about criticism, about, er, you know, being held unduly responsible, so I think that's a, a real fear. We have to reduce the bed occupancy and, and ideally the number of beds on, on, in each ward. So if we reduce the number of beds but reduce the staff-patient ratio that would not be effective, but reducing the number of beds, er, maintaining the staff ratio, er, reducing the turnover, er, I think would automatically create a more caring environment.

Indeed, the restrictions or barriers to effective caring were indicated in the aspirational quality of "trying" to help, as in the sample concordance lines shown in Figure 5. Overall, a focus in the corpus on paperwork, time, processing, and environmental restrictions, as opposed to interaction with patients, indicates the emergence of a production-line mentality (Crawford & Brown, 2011) that interrupted or blocked compassionate care.

Institutional Mentality and Emotional Distancing

The naming of actors was limited to institutional, homogeneous references to *patient/patients* ($n = 225$), *people* ($n = 170$), *staff* ($n = 136$), or *somebody* ($n = 65$), with much less or little emphasis on *person/persons* ($n = 40$), *individual/individuals* ($n = 35$), *men* ($n = 6$), and *women* ($n = 2$). Indeed, there was surprisingly little use of terms that indicated less institutional and more consumer-focused or negotiated approaches to care: *client/clients* ($n = 7$), *users/user* ($n = 9$), *service user/service users* ($n = 6$). There was no mention of *recover/recovery* in the corpus, or the concept of alleviation of distress or suffering as

person that sense that you really are trying to **help** them and really are trying to / with their feelings and trying to, trying to **help** them in whatever way we can / holistic I suppose isn't it? Trying to **help** somebody with every aspect of their life / the patient to it but always try and **help** them, you know, we've always got to / in danger we, we discuss it and, err, try and **help** the person as much as we can

Figure 5. Sample concordance lines for "help."

being the most important focus of compassion. This is telling given that a recovery approach is increasingly prominent in policy debates, both challenging the authority and expertise of traditional mental health care service developments and emphasizing the importance of service-user perspectives (Beresford, Nettle, & Perring, 2010; Davidson, Rakfeldt, & Strauss, 2010; Repper & Perkins, 2003).

The absence of any reference to recovery or service-user-focused care suggests that the practitioners were caught up in an ethos in which care was from professionals to patients in a top-down way, and in which the expertise or personhood of those suffering mental distress was overlooked. It fits with a production-line mentality and environment, where "us and them" framings apply in processing individuals through a health care service. That being said, it is not clear whether the work environment solely influenced language choices or if the background and education of the practitioners might also have been a factor. Revealingly, there were only two references to wider services, with a localized or restricted vision of environment in terms of *ward/wards* ($n = 218$), *room/rooms* ($n = 82$), *hospital* ($n = 16$), and *place* ($n = 16$), and that there was *nowhere* ($n = 11$) for them or those they were caring for to go. It is precisely this kind of entrapment that results in stress (Gilbert, 2009) and militates against a compassionate mentality and care.

Terms that are prominent in most definitions of compassion, such as *kind*, *gentle*, *warm*, and *friendly* (not to mention many other linguistic constructions that express kindness and compassion), were rarely used by staff here. Although we would not anticipate explicit reference to friendship, per se, given the professional context of care, the affective quality of emotional distance is noteworthy. Despite the emphasis in counseling and mental health communication literature on being warm, concerned, empathic, sympathetic, open, nonjudgmental, calming, reassuring, respectful, or validating, these attributes and their lexical variants are barely visible. This is matched by a clear distancing from attributes of being loving or affectionate, with only one reference to a lexical variant of the attribute of loving and none at all for that of being

affectionate. The act of feeling for self/others or being sensitive to what self and others require is evident in the frequency of *feel* ($n = 97$) and *need* ($n = 95$). The frequencies for these base terms, however, fall well short, comparatively, when set against respective sizes of corpora. Overall, we might consider an emotional thermometer for how the practitioners in the current study talked about compassion: their work would register a low reading. We can note, for example, when looking more broadly at the data, that lexical items concerned with social cohesion and shared activity were relatively rare: *together* ($n = 15$), *belong/belongs/belonging* ($n = 0$), *share/shared/sharing* ($n = 1$), *work/worked with* ($n = 12$), *be/being with* ($n = 7$). This is concerning, because it indicates problems of actually engaging with a compassionate mentality in the current threat-dominated work environments.

Study Limitations

In this study we analyzed a relatively small number of narratives from practitioners in two acute mental health units in the United Kingdom, and therefore cannot generalize our findings. However, Baker (2006) and Atkins and Harvey (2010) both indicated that the use of smaller corpora can be valuable in corpus-assisted discourse analysis. Bias in qualitative interpretation was moderated by cross-disciplinary expertise across the fields of mental health and applied linguistics, and the quantitative accounting of language through the application of AntConc software (Anthony, 2011). Although naturally occurring data are preferred in health language research and discourse analysis generally, topic-specific interview narratives allow for a targeted study of a particular phenomenon, in this case perspectives on compassion in acute mental health care.

Conclusion

Compassion is something that many people recognize as important when it comes to dealing with mental health distress and suffering. For compassion development within mental health services to become more than just another government “tick box” standard or target to meet, there will need to be considerably more research on the genuine psychological nature of compassion, what facilitates it, and what inhibits it. Although compassion is often regarded as being possessed by individuals, in fact we now know that behaviors, both good and bad, are significantly influenced by the environments in which individuals are embedded. So how is compassion thought about by mental health workers?

From this study, we can make a few preliminary observations based on our analysis of the AMHP corpus. First, there was little description of compassion in the interviews despite the topic focus on compassion and compassionate

working. Second, a production-line mentality appears to have intruded into the discourse of the practitioners, with multiple references to heightened threat around managing and processing patients to reach targets amid personnel or other resource shortages, including time. Finally, the language indicated both an institutional mentality and emotional distancing between practitioners and patients, despite concern for delivering a quality service. Although we should not conclude from these observations that practitioner participants were noncompassionate in their practice, their language choices revealed a clear difficulty in articulating compassion and a displacement of a compassionate mentality by the threat stress clearly linked to a production-line approach to care delivery.

Additional research, of course, is required if we are to achieve a rich understanding of a language of compassion in health care, the way cultures of health care effect and are affected by language choices, and how language activates our psychology and emotional engagement in compassionate ways. We need to look beyond interview narrative to gain a richer perspective that encompasses a range of health language performances. Such research might, for example, investigate (a) naturally occurring or everyday compassionate language in consultations or other face-to-face interactions with health care users; (b) keywords for a language of compassion in large corpora of health language in the media, Internet postings, policy documents, guidelines, and organizational communication; (c) how low or high levels of compassionate language in such texts impact on practitioners’ understandings of their roles, discourses, and practices; (d) the impact of compassionate language on service user and carer experiences; and (e) whether nonverbal social transactions manifest compassion more readily than spoken or written discourses.

Certainly, our study findings suggest that there is fertile ground for health communication researchers and educators to examine critically how the dominant registers of biomedicine, clinical technique/technology, and economic or productive efficiency might drive out compassionate words and phrases and ineluctably advance compassion depletion in health services, not least mental health. Our research calls for policy makers and health care managers to invest in the compassionate design (Crawford, 2011) of those services. This means looking beyond individual practitioner attitudes and behaviors to focus more explicitly on how organizational, environmental, and process changes might promote compassionate care. Also, we suggest that cross-disciplinary approaches to research that make use of the insights from different disciplinary backgrounds in health care and from applied linguistics could prove valuable in advancing new knowledge about the nature and impact of health language. Finally, taking a global perspective, the language of compassion in health care should be investigated in diverse languages and cultures.

Appendix I. Interview Schedule

Setting the Tone

Thank you for agreeing to participate in this interview. This research is about people's thoughts, views, and experiences of compassion. For the next hour or so we will explore your ideas about compassion and your experiences of how this is applied in your workplace. As I said, my name is Jean Gilbert. I will be recording this interview and making notes as we go along. This is so that the conversation can be written up, which will allow me to look at the different themes and ideas that you generate.

We will be covering a range of different topics and ideas today, and please do contribute whatever occurs to you that you feel is relevant. This research is very much about your experiences. There will be times when it will be helpful to discuss an idea in more detail and therefore I will ask you about it. There are no right or wrong answers, this is just about your experiences and views. I hope you enjoy the evening/afternoon.

Understanding of Compassion

1. I would like to start by asking you what you understand compassion to mean. Prompt: What does the word compassion mean to you?
2. What do you see as the key qualities of a compassionate person? Prompts: What do you see as the key qualities of being compassionate? If someone was being compassionate toward someone else, what would that be like?

Example of compassion if they are struggling:

Compassion has been defined by the Dalai Lama as "an openness to the suffering of self and others with a commitment to relieve it." Compassion can also include attentiveness, sensitivity, warmth, and kindness—but the main focus is a concern to relieve distress. So for our research we'd like to explore two aspects of compassion:

- First I will explore with you what you think gets in the way of you providing high-quality compassionate care for your patients in the way you would like to do so.
 - Second I will explore what things could facilitate you in being able to provide higher-quality compassionate care than you do at present.
3. What do you feel constitutes compassionate care in your area/patient group?
 4. What would facilitate you in being able to provide higher quality compassionate care? Prompts:

- A better facility/location for you to work with your patients
 - More flexibility with your allocated time
 - More support from colleagues and management
 - More autonomy within your role
 - Better care from other professionals
5. What do you think gets in the way of your area providing high-quality compassionate care of the form you might like to provide? Prompts:
 - What are your general feelings about your workplace?
 - Is this facility the correct one for you to carry out your role?
 - Are your colleagues and/or management interested in the fact that you do a good job?
 - Do you have sufficient time to undertake your role satisfactorily?
 - Are you pressured to do too many other tasks and thereby unable to do your job as well as possible?
 6. Is there anything you feel we haven't talked about today that you would like to add?

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Note

1. Lexical variants are all the different forms of a base word. For example, variants of *support* could include *supports*, *supported*, *supporting*, and *supportive*.

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