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Informal Coercion and the Escalation of Violence in Mental Health Settings: A Large-Scale Qualitative Study

Abstract

Workplace violence is a persistent and complex challenge in mental health settings, affecting staff wellbeing, patient care, and organisational stability. While violence is often linked to coercive practices, research has primarily focused on formal interventions such as restraint and seclusion, with limited attention to everyday interactional dynamics. This study investigates how mental health staff construct and describe the situational dynamics of patient–staff violence using large-scale incident report data. A qualitative thematic analysis was conducted on 3,995 incident reports recorded in a regional mental health system in Denmark (2015–2020). Using an interactionist perspective and an iterative coding process, 24,832 coded segments were organised into thematic structures. Findings indicate that violent incidents are rarely described as isolated events but rather as temporally ordered interactional sequences. A consistent pattern emerged in which staff-initiated attempts to regulate or redirect patient behaviour preceded escalation. Informal coercive practices, particularly behavioural correction and refusal of patient requests, were frequently described in close proximity to increasing agitation and aggression, whereas formal coercive measures were typically documented as responses to already escalated situations. These findings suggest that workplace violence emerges through dynamic staff–patient interactions embedded in routine clinical practice. The study highlights the importance of everyday communication, behavioural correction, refusal of patient requests, and wider relational practices and suggests a shift in focus from formal coercion to interactional mechanisms in violence prevention.

Keywords: Workplace violence; Incident reporting; Informal coercion; Restrictive practices; Mental health nursing

Background

Workplace-related violence is a persistent and well-documented challenge in mental health services, affecting both staff safety, wellbeing, and organisational stability (Itzhaki et al., 2015; Kelly et al., 2016; Odes et al., 2021; Sahebi et al., 2022). Mental health professionals, particularly nurses, are at elevated risk of exposure to threats and physical assault compared to other healthcare groups, with substantial psychological and occupational consequences, including distress, fear, and staff turnover (Berger et al., 2024; Hilton et al., 2022; Itzhaki et al., 2018). Within mental health settings, violence is closely intertwined with the use of coercive and restrictive interventions. While such measures, including mechanical restraint, seclusion, and forced medication, are often employed to prevent harm and manage escalating situations, their use has also been associated with adverse outcomes and may contribute to further conflict and aggression (Baker et al., 2021; Cusack et al., 2018; Pedersen et al., 2023; Steinert et al., 2010). This reflects a well-documented paradox in the literature: coercion is both a response to violence and a potential contributor to its escalation (Maguire et al., 2014; Wynn, 2003).

Research has increasingly highlighted the importance of staff–patient interactions in shaping the emergence of violent incidents. Factors such as social climate, staff attitudes, limit setting, and everyday care practices are central to how conflicts develop and unfold (Asikainen et al., 2020; Duxbury & Whittington, 2005; Papadopoulos et al., 2012; Price & Baker, 2012). The Safewards model has been particularly influential in conceptualising conflict and containment as emerging from interactions between patients, staff, and the wider ward environment (Bowers, 2014). Rather than locating violence solely within individual patients, Safewards emphasises how interpersonal, organisational, and environmental factors contribute to conflict in mental health settings. While Safewards identifies domains and processes associated with conflict generation and has demonstrated effectiveness in reducing conflict and containment, fewer studies have examined

how these interactional dynamics are documented and described by staff within routine incident reporting systems. However, much of the existing literature focuses on prevalence, outcomes, and formal coercive practices, with limited attention to how staff themselves describe and interpret the situational dynamics leading to violence in everyday clinical contexts. Large-scale analyses of routine incident reports remain relatively uncommon, despite offering unique insight into how staff construct and document the events preceding violent encounters. By analysing narrative incident reports, the present study complements the Safewards literature and broader research on conflict, containment, and violence prevention by examining how relational tensions, informal coercion, and interactional processes are recorded as antecedents of violent incidents. Addressing this gap is critical for developing a more nuanced understanding of escalation mechanisms and informing interventions aimed at reducing both violence and the use of coercion in mental health settings.

Aim

To investigate how mental health staff construct and describe the situational dynamics of patient–staff violence and threats in large-scale workplace incident report data.

Method

This study employed qualitative thematic analysis to examine mental health staff's written accounts of workplace incidents involving patient–staff violence and threats. The analysis was informed by Blumer's methodological principles for the study of the empirical social world, emphasising systematic engagement with empirical instances, the disciplined collection and examination of data, the identification of relationships between categories, and the iterative

development of explanatory propositions (Blumer, 1986). This approach is particularly suited to analysing how actors assign meaning within situated interactions.

Data

Data were obtained from a regional mental health incident reporting system in the southern part of Denmark, covering a six-year period (2015–2020) and including incidents reported across mental health hospital services, including inpatient wards, outpatient clinics, and patient reception and waiting areas. In the Danish mental health system, workplace violence is routinely registered as a formal incident report following aggressive or threatening events. A total of 4,901 incident reports were retrieved. Reports not containing descriptions of violence, based on the World Health Organization definition of violence (WHO, 2002), were excluded (n = 906), resulting in 3,995 reports included in the analysis. Within the reporting system, incidents were categorised using predefined violence categories. Physical violence referred to direct physical assaults, including actions such as hitting, kicking, being struck by an object, choking, biting, or scratching. Psychological violence referred to threats, threatening behaviour, verbal abuse, harassment, bullying, and sexual harassment. These classifications were established within the reporting system and were not developed by the research team. Each report contained a free-text description structured around three elements: events preceding the incident, the incident itself, and subsequent actions. Reports were typically documented shortly after the event and reflect the perspective of the reporting staff member. The dataset primarily represents frontline clinical staff, including registered nurses and social and healthcare assistants. Descriptive characteristics of staff and incidents are presented in Table 1.

Analysis

Consistent with Blumer's methodological position, the analysis was guided by the principle that inquiry should remain grounded in the empirical world and attentive to how social actors define situations and assign meaning through interaction (Blumer, 1986). Consequently, symbolic interactionism was employed as a methodological orientation rather than an interpretive theory, allowing categories, patterns, and meanings to emerge through systematic engagement with the incident reports. Data were analysed using Empirically Testing Thematic Analysis (ETTA), a thematic analytic approach grounded in symbolic interactionism (Gildberg et al., 2015). ETTA conceptualises coding, categorisation, thematisation, and theme development as successive stages within a broader thematic analytic process involving empirical testing, taxonomic organisation, and recontextualisation of themes in relation to the original empirical material (Gildberg et al., 2015). Iterative codebook development procedures described by Braun et al. (2019) were applied during the coding phase of the analysis. Coding and categorisation were therefore regarded as intermediate analytical steps rather than analytical end points. The analysis was conducted in relation to the study aim and analytical focus on how staff described and constructed the interactional processes preceding violent incidents. Consistent with Spradley's concept of the social situation, the incident descriptions were treated as accounts of interactional situations involving actors, activities, places, and temporal contexts (Spradley, 1980b). Accordingly, all free-text descriptions (n = 3,995) were read repeatedly to achieve familiarity with the data. Initial coding was conducted inductively, with codes assigned to segments of text capturing key elements of the reported situations (Gildberg et al., 2015). A structured codebook was developed iteratively, with explicit inclusion and exclusion criteria applied to ensure consistency. In total, 465 codes were generated and systematically applied across the dataset, resulting in 24,832 coded segments.

Coding was conducted by two authors, and discrepancies were addressed through discussion and consensus to enhance analytical rigour (Braun et al. 2019). The coding process resulted in a hierarchical classification system of interactional elements, including staff-initiated actions (e.g., behavioural correction and refusal of patient requests), patient responses (e.g., agitation and resistance), and incident outcomes (e.g., threats and physical violence). Codes were subsequently grouped into themes using taxonomic analysis, focusing on part–whole relationships between categories using the semantic relationship 'A is a part of B' (Gildberg et al., 2015; Spradley, 1980a). Themes were continuously refined, empirically tested, and recontextualised through repeated comparison with the original incident reports to ensure coherence, validity, and consistency with the empirical material. This iterative process supported the identification of recurring patterns in how staff constructed and described the dynamics of violent incidents and enabled the conceptualisation of incidents as temporally ordered sequences of interactional events rather than isolated occurrences. The full coding framework, including all codes and their hierarchical organisation, is provided in Appendix 1. This comprehensive thematic overview forms the analytical foundation of the study and supports transparency and reproducibility of the coding process. Additionally, the structured coding framework provides a basis for translating qualitative interactional elements into analytically distinct components that can be operationalised in future quantitative analyses of escalation processes.

Ethics

The study was conducted with full approval on all organizational levels and follows ethical guidelines provided from the declaration of Helsinki and the Nuremberg Code (Association, 2008; Tribunal, 1949). Data was handled and stored in accordance with the EU General Data Protection

Regulation. The protocol was approved by the Regional Research Ethics Committee case no: xxx and the Regional Danish Data Protection Agency case no: xxx. The requirement for informed consent was waived, as the study was based on secondary analysis of anonymised incident report data, and approval was obtained from above mentioned ethics and data protection authorities.

Results

The analysis included 3,995 incident reports from 1,540 mental health staff members describing workplace violence and threats (Table 1).

[insert table 1 about here]

Physical violence accounted for most incidents (61.6%), while psychological violence comprised 38.4%. The dataset primarily reflects frontline clinical staff, particularly nurses and social and healthcare assistants, working predominantly in adult mental health services. Most staff reported a limited number of incidents, with the majority submitting between one and five reports (Table 2), indicating that exposure to violence was widespread rather than confined to a small subgroup of staff.

[insert table 2 about here]

Within the overall coding framework, staff-initiated behavioural regulation activities constituted some of the most frequently occurring elements in the dataset, including behavioural correction (n = 2,028) and refusal of patient requests (n = 688). These activities were not only prevalent but were frequently described in close temporal proximity to escalating interactions. Across the dataset, incidents were described as unfolding within complex and context-dependent social situations.

While variation was observed in terms of location, time, and participants, a consistent pattern emerged: staff-initiated attempts to regulate or redirect patient behaviour frequently preceded escalation into violence.

Theme overview

Three overarching themes were used: (1) actors, (2) location, and (3) temporal context (Figure 1). These themes describe the structural elements of the reported situations; however, the analysis moves beyond categorical description to examine how interactions between staff and patients unfold over time.

[insert figure 1 about here]

Violent incidents were rarely described as isolated events. Instead, they were embedded in sequences of interaction, where staff actions and patient responses developed in relation to one another. In particular, staff efforts to manage, correct, or limit patient behaviour were repeatedly described as part of the processes leading to escalation. Several of the most prominent coded elements were related to staff-initiated behavioural regulation, indicating their central role across incident descriptions. A detailed overview of the thematic structure, including subcategories and coding frequencies, is presented in Appendix 1.

Main theme: Actors – staff activities

Within the theme "actors", staff-related activities played a central role in shaping how incidents were described (Figure 2).

[insert figure 2 about here]

Staff actions were typically embedded in ongoing interactions and oriented toward managing behaviour, enforcing rules, or responding to patient needs. These activities included coercive measures, treatment-related actions, and procedural transitions (Figure 3). Procedural transitions referred to situations involving the transfer of patients between clinical settings.

[insert figure 3 about here]

However, they did not contribute equally to escalation. A recurring pattern concerned activities directed at regulating patient behaviour, particularly behavioural correction (n = 2,028) and refusal of patient requests (n = 688). These were among the most frequently occurring staff-initiated activities identified across the dataset. These practices were often not framed as coercive but as part of routine care. ‘Correction’ involved attempts to redirect behaviour, enforce ward rules, or deny requests related to immediate needs such as smoking, food, or movement. Across reports, such actions were frequently described in close temporal proximity to escalation. For example, in one case (ID 4), a patient displaying threatening behaviour was corrected verbally by staff, after which the situation escalated rapidly:

> *"...the patient was verbally threatening and stated that if medication was not provided immediately, he would probably assault a nurse. The patient was corrected regarding this behaviour. The patient then grabbed the staff member by the shoulders and moved his hands up to the staff member's neck, briefly applying a choke hold..." (ID 4)*

Similarly, attempts to enforce rules were described as immediate triggers of violent responses. In another case (ID 48), a patient repeatedly attempted to leave the ward and was redirected by staff:

> *"...the patient was guided back to the room and informed that his keys would not open the doors. The patient could not be corrected and suddenly shouted, 'Then give me those keys now!' before striking the staff member..."* (ID 48)

Situations involving refusal of patient requests (n = 688) showed similar patterns. Across these incidents, refusals and attempts to redirect behaviour were often followed by escalating patient responses. For example, in one case where a patient request could not be accommodated:

> *"...I explained that this was not possible, but that he could be seen by our doctor. Following this, the patient became extremely agitated, threw furniture, attempted to smash the door with a chair, and threatened to kill me and crush my throat..." (ID 46)*

These quotations are illustrative examples drawn from a much larger body of incident descriptions. Behavioural correction was identified in 2,028 reports and refusal of patient requests in 688 reports, indicating that the interactional patterns illustrated above were recurrent across the dataset rather than confined to isolated incidents. Across many reports, these forms of behavioural regulation were closely associated with escalation. Staff descriptions often link attempts to correct or restrict behaviour to patient frustration, resistance, and aggression. In several cases, escalation unfolded in sequences in which an initial staff action was followed by increasing agitation and eventually physical or verbal violence. Viewed within the overall coding structure, these forms of behavioural regulation can be understood as analytically distinct interactional components that recurrently appear in sequences leading to escalation. Their frequency and consistent positioning within incident descriptions suggest that they constitute key elements in the interactional processes underlying violent incidents. Formal coercive measures, including mechanical restraint, physical

restraint, and rapid tranquilisation, were also present. However, these were typically described as responses to already escalated situations rather than initiating factors. In contrast, informal practices embedded in everyday interactions appeared more directly connected to the onset of conflict. Overall, the findings indicate that informal coercive practices, particularly behavioural correction and refusal, play a central role in the development and escalation of violent incidents.

Staff – role

Staff roles were occasionally specified (Figure 4), for example whether the staff member was alone, acting as a colleague, or serving as a contact person or patient guard.

[insert figure 4 about here]

These descriptions provided contextual detail but were rarely elaborated upon. The data suggests that escalation was less dependent on formal role and more closely related to how staff interacted with patients in practice. For example:

> *"...the patient became agitated and angry because she felt that the injured staff member had not shown sufficient care in the role as contact person..." (ID 41)*

Similarly, another report described how:

> *"...the patient was met by the contact person, who attempted to calm the patient..." (ID 140)*

Main theme: Actors – patient activities

Patient-related activities reflected a wide range of behaviours, illustrating the complexity of situations in which violence occurred (Figure 5).

[insert figure 5 about here]

These included dissatisfaction, treatment refusal, verbal and physical threats, and behaviours described as conflict-seeking. Certain behaviours were frequently associated with escalation, particularly threatening behaviour (n = 1,743), conflict-seeking behaviour (n = 1,660), treatment refusal (n = 503), psychological violence (n = 1,535), and physical violence (n = 2,460). Incidents often involved unmet needs, disagreements over rules, or refusal of treatment, with patients described as agitated or challenging staff decisions.

> *"...the patient became very angry because she felt that the doctors would not help her and wanted medication to sleep ... the patient became more angry and upset because she believed the medication would not help..." (ID 33)*

In other reports, threatening behaviour was described more explicitly:

> *"...it is a damn shame that I did not bring the knife inside because then I would have stabbed you ... I will kill you ... you are going to die..." (ID 66)*

However, these behaviours were not presented as isolated triggers. Instead, they were embedded in interactional sequences in which patient responses developed in direct relation to preceding staff actions. For example, in one case (ID 14), a patient reacted aggressively when asked to comply with staff instructions:

> *"...the patient was asked to go into the garden and close the door behind her ... instead of complying with staff instructions, the patient suddenly and without warning slapped the staff member..." (ID 14)*

Across reports, resistance, threats, and physical aggression were often described following attempts by staff to regulate or restrict behaviour. Although some incidents were described as sudden or unpredictable, most developed through ongoing interactions between staff and patients.

This suggests that violence cannot be attributed solely to patient characteristics but emerges through relational dynamics.

Interactional dynamics of escalation

Taken together, the analysis shows that workplace violence emerges through interactional processes rather than isolated events. Across the dataset, a consistent pattern was identified in which staff-initiated behavioural regulation interacted with patient responses to produce escalating sequences of conflict. These processes were characterised by a dynamic interplay between staff actions and patient reactions, often developing over time. Informal coercive practices, particularly correction and refusal, frequently marked the transition from routine interaction to conflict and, ultimately, violence. One report succinctly illustrated this escalation pattern:

> *"...the patient repeated 'I want to leave' ... the staff member corrected the patient ... the patient moved closer ... the patient stepped forward and grabbed the staff member very hard and firmly by both upper arms ..." (ID 156)*

A similar sequence involving correction, refusal, and subsequent violence was described in another report:

> *"...the staff member corrected the patient ... the patient refused the offered medication and threw the medication cup away ... the patient then stood up and struck the staff member three times..." (ID 47)*

This quotation illustrates a recurrent interactional sequence identified across the dataset, in which staff attempts to regulate, redirect, or restrict behaviour were followed by escalating patient responses. Similar patterns were observed across a substantial proportion of the reports coded as behavioural correction (n = 2,028) and refusal of patient requests (n = 688).

Discussion

The present study suggests that violence in mental health settings cannot be adequately understood as the product of patient pathology or isolated situational triggers alone. Rather, violence appears to emerge through interactional processes in which attempts to regulate behaviour become consequential moments in the negotiation of authority, autonomy, compliance, and resistance. From this perspective, informal coercive practices embedded in everyday staff-patient interactions appear not merely as antecedents of violence, but as central interactional mechanisms through which escalation is produced and sustained. Across a large and diverse dataset, staff accounts frequently positioned attempts to regulate, correct, or restrict patient behaviour as critical moments in the development of conflict and subsequent violence. These findings extend perspectives that primarily locate the origins of workplace violence in patient pathology or acute situational triggers and instead support an interactional understanding in which violence emerges through processes embedded in routine clinical practice.

This interactional emphasis is strongly supported by existing evidence. A large meta-analytic review found that staff–patient interaction is the most frequent antecedent of violent incidents, accounting for approximately 39% of cases, with restriction of patient autonomy, such as denying requests or limiting freedoms, being the single most common trigger (Papadopoulos et al., 2012). Similarly, empirical work has shown that patients frequently identify poor communication, restrictive environments, and interpersonal tensions as key precursors of aggression, highlighting the centrality of relational dynamics (Duxbury & Whittington, 2005). The present study extends these findings by demonstrating how such interactional dynamics unfold as temporally ordered sequences rather than isolated antecedents, thereby providing a more process-oriented account of escalation. Conceptually, this suggests that conflict may be less appropriately

understood as a response to discrete triggers and more appropriately understood as a relational process in which actions and responses acquire meaning through their sequential position within an interaction. These findings are also consistent with the Safewards model, which conceptualises conflict and containment as arising through interactions between patients, staff, and the ward environment rather than solely from patient characteristics (Bowers, 2014). However, the present study complements this literature by demonstrating how specific forms of informal coercion, particularly behavioural correction and refusal of patient requests, are repeatedly documented within staff accounts of escalating incidents. In contrast to existing models that conceptualise staff actions such as limit setting as discrete antecedents (Duxbury & Whittington, 2005; Papadopoulos et al., 2012), the present study suggests that these actions are embedded within dynamic interactional sequences that may generate escalating responses. This shifts the analytical focus in the present study from identifying triggers of violence to examining the mechanisms through which violence may be co-constructed in interaction.

Also, a key contribution of the study lies in shifting the analytical focus from formal to informal coercion. Previous research has primarily examined formal coercive interventions, such as restraint and seclusion, which are typically conceptualised as responses to escalating risk (Steinert et al., 2010). However, evidence suggests that such interventions are associated with significant adverse effects, including psychological distress, fear, and trauma (Cusack et al., 2018), as well as broader negative subjective experiences (Chieze et al., 2019). While this body of work has been essential in highlighting the harms of coercion, it has tended to focus on the endpoint of escalation rather than its early phases. The present findings suggest that the roots of escalation may lie in everyday, less visible practices that precede formal interventions. Importantly, these forms of behavioural regulation are rarely enacted as punitive measures. Rather, they are embedded

within routine clinical work and are often framed as necessary components of care, safety management, treatment, and organisational order. Their significance therefore lies not in their formal status but in how they are experienced, interpreted, and responded to within specific interactional situations. Viewed within the context of institutional psychiatric care, this is perhaps unsurprising. Psychiatric institutions have historically relied on everyday forms of behavioural regulation to maintain order, routines, and organisational predictability (Foucault, 1979; Goffman, 1961). As a result, actions that restrict patient autonomy may become normalised as ordinary and legitimate components of care rather than recognised as coercive practices. Through their repeated enactment in everyday clinical work, such practices may become institutionally reproduced and sustained as ordinary features of psychiatric care, even when they restrict patient autonomy. The present findings suggest that these routine institutional practices continue to constitute important interactional moments in contemporary psychiatric settings and may contribute to escalation when they become points of tension between institutional expectations and patient preferences. In this respect, the study contributes to a growing recognition that coercion operates along a continuum. Informal practices such as behavioural correction, limit setting, and refusal of requests are integral components of daily care and are often enacted without being conceptualised as coercive. However, the findings suggest that these practices may function as early interactional mechanisms in escalation processes, shaping patient responses and interactional trajectories. This aligns with broader literature emphasising that staff approaches, communication styles, and ward practices are key determinants of violent incidents (Asikainen et al., 2020). Importantly, it also suggests that the distinction between formal and informal coercion may be analytically insufficient, as both operate within the same relational and interactional dynamics.

These findings further refine the well-described paradox of coercion in psychiatric practice. Coercive actions are frequently justified as necessary responses to violence and risk, yet they may also contribute to the escalation they are intended to prevent (Wynn, 2003). The present study extends this paradox by suggesting that it is not limited to formal interventions but is embedded in everyday interactional practices. Attempts to regulate behaviour may simultaneously function as efforts to maintain safety and as stimuli that generate resistance, frustration, or perceived injustice. In this sense, coercion can be understood as a relational process through which control and resistance are co-produced, rather than as separate phenomena originating from either staff or patients alone. Attempts to establish order, maintain boundaries, or regulate behaviour may therefore simultaneously generate opposition and contribute to the very escalation they seek to prevent. The findings also provide a more fine-grained understanding of the role of de-escalation and interactional skills in managing violence. De-escalation has been widely promoted as a key strategy for preventing aggression, with evidence highlighting the importance of communication, interpersonal engagement, and timing of interventions (Price & Baker, 2012). However, the present study suggests that escalation may begin prior to the point at which de-escalation strategies are typically implemented. Informal coercive actions may already have shaped the interactional context in ways that increase the likelihood of escalation. This indicates that prevention efforts must extend beyond crisis management and address the routine practices through which interactions are structured.

At the same time, these findings must be interpreted within the context of clinical reality. Mental health staff operate in environments characterised by unpredictability, risk, and competing demands. The use of informal coercion may reflect efforts to maintain order, ensure safety, and manage limited resources. Research has shown that staff must continuously balance safety,

therapeutic engagement, and the management of clinical risk, a tension that is inherent in psychiatric practice (Gildberg et al., 2013; Wynn, 2003). The present findings do not suggest that such practices are avoidable or inappropriate, but rather that their interactional consequences warrant greater attention. From a clinical perspective, these findings underscore the importance of focusing not only on what staff do, but on how they do it. Communication, relational engagement, and the manner in which limits are set appear to be critical in shaping patient responses. Reviews of violence prevention strategies have identified communication, leadership, and reflective practices as key components in reducing aggression and coercion (Asikainen et al., 2020). The present study suggests that such interventions may be enhanced by explicitly addressing the interactional dynamics of behavioural regulation, including how refusals and corrections are enacted in practice. These tensions should not be understood solely as the result of individual staff choices. Rather, they reflect broader organisational expectations regarding order, risk management, and behavioural regulation that shape everyday interactions between staff and patients.

The study also has implications for organisational approaches to violence prevention. The findings indicate that organisational approaches focusing exclusively on individual staff competencies or patient risk factors may overlook important relational and institutional mechanisms embedded in routine care practices. Traditional efforts have focused on reducing the use of formal coercive interventions through policy and procedural changes. While reducing formal coercion remains important, organisational efforts should also address the interactional environment in which escalation processes unfold. Supporting staff in reflecting on their everyday practices, increasing awareness of escalation processes, and fostering relational approaches to care may be essential components of effective prevention strategies. Finally, the study points toward a need for a more process-oriented research agenda. By identifying a reproducible interactional

structure underlying escalation, the findings provide a preliminary framework for examining violence as a process rather than an event. This distinction is important because it shifts analytical attention away from static risk factors and toward the ways interactions develop, accumulate, and eventually reach points at which violence becomes possible. Variables such as behavioural correction, refusal of requests, and patient resistance can be operationalised and examined in relation to their temporal ordering and cumulative effects. Recent research has highlighted the need to better understand the antecedents and trajectories of aggression in inpatient settings (Sterri et al., 2025), and the present study contributes to this agenda by offering a model that integrates interactional dynamics with empirical analysis.

Taken together, the findings shift the focus of violence research from identifying static risk factors to understanding the dynamic processes through which violence emerges. While behavioural regulation, correction, and refusal are often understood as routine elements of psychiatric care, the present findings suggest that these practices may also function as institutional mechanisms through which authority, autonomy, and compliance are negotiated. Viewed in relation to the literature on institutional psychiatric care, informal coercion may therefore be understood not simply as a set of individual staff actions but as a normalised and organisationally embedded feature of everyday practice that can become interactionally consequential under specific circumstances and contribute to the maintenance and negotiation of institutional order (Goffman, 1961). The present study constitutes the first step in a broader programme of research aimed at systematically examining the interactional mechanisms underlying violence in mental health settings. Building on the identification of an informal coercion escalation process and its constitutive elements, subsequent analyses will seek to operationalise these components within large-scale datasets, enabling quantitative examination of their temporal ordering, interaction, and

predictive value in relation to violent outcomes beyond the qualitative analysis undertaken in the present study. In this way, the current study establishes an initial conceptual and analytical foundation for further empirical investigations of escalation processes across settings.

Limitations

Several limitations should be considered when interpreting the findings. Although the database includes 3,995 incidents over a five-year period, underreporting of workplace violence in mental health settings is well documented (Gifford & Anderson, 2010; Spencer et al., 2023). Staff may refrain from reporting incidents due to limited knowledge of reporting procedures, perceptions that reporting has limited impact, burdensome administrative processes, or concerns about potential repercussions. As a result, minor incidents and near misses, potentially important for understanding early escalation processes, are likely to be underrepresented in the dataset. The study is based exclusively on staff-reported incident data. Consequently, the descriptions reflect staff perspectives, interpretations, and situational framings of events, which may influence how incidents are constructed, interpreted, and narratively framed. Patient perspectives are not included, limiting the ability to capture alternative interpretations of the same situations and potentially constraining a full understanding of the interactional dynamics leading to violence.

Furthermore, incident reports may serve not only as descriptions of events but also as professional accounts produced within an organisational reporting system. Staff may therefore be more likely to document actions that are consistent with policies, procedures, and professional expectations, while interactional elements that could be interpreted as errors, misjudgements, provocative remarks, or other potentially contributory staff behaviours may be omitted, underemphasised, or not recognised by the reporting individual. Consequently, the reports should be understood as staff-

constructed accounts of incidents rather than comprehensive or objective descriptions of all interactional aspects of the events.

An additional limitation concerns variability in reporting quality. The incident reports vary considerably in level of detail and descriptive richness, ranging from brief summaries to more elaborate accounts. This variability affects how situations can be interpreted, coded, and analytically integrated, and may lead to uneven representation and differential analytical visibility of contextual and interactional features across cases. Furthermore, as the database was not originally designed for research purposes but for administrative incident reporting, it lacks systematically collected information on potentially relevant variables. This includes detailed contextual data, contributing factors, de-escalation attempts, psychological impact on staff, and longer-term consequences of violent incidents. As a result, the analysis was constrained in its ability to fully reconstruct the complexity and temporal unfolding of incidents. At the same time, the use of routinely collected incident data also represents an important strength. The data reflect real-world clinical practice as documented by staff in situ, capturing naturally occurring interactions across a large number of cases and settings. This enhances ecological validity, even if it limits depth in individual cases. Finally, the dataset reflects a Danish mental health context shaped by specific organisational structures, legal frameworks, and care practices. This may limit the transferability of the findings to contexts with differing organisational, legal, or cultural conditions. Taken together, these limitations may influence how incidents are described, interpreted, and analytically represented, and should be considered when evaluating the findings and their broader applicability. In addition, the analysis relies on retrospective written accounts, which limits the ability to directly observe interactional sequences as they unfold in real time. Consequently, the temporal ordering and dynamics identified in the analysis are reconstructed from

staff descriptions rather than independently observed interactions and should be interpreted accordingly.

Conclusion

This study suggests that workplace violence in mental health settings emerges through interactional processes embedded in everyday staff–patient encounters. In particular, informal coercive practices, such as behavioural correction and refusal of patient requests, appear to constitute key mechanisms in the escalation of conflict and subsequent violence. By shifting the focus from formal coercive interventions to micro-level interactional practices, the study provides new insight into how routine clinical actions may unintentionally contribute to escalation. These findings highlight the importance of understanding violence as a relational phenomenon shaped through ongoing interactions rather than isolated events. The results suggest that prevention efforts should extend beyond reducing formal coercion to include greater attention to everyday communication, behavioural regulation practices, including behavioural correction and refusal of patient requests, and wider interactional practices. The study offers a foundation for future research aimed at operationalising these mechanisms in quantitative analyses and developing targeted interventions to reduce both violence and coercion in mental health care.

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Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work, the authors used the university-licensed Copilot (GPT-5) to improve and refine the language, as English is not their first language. All content was subsequently carefully reviewed and edited by the authors, who take full responsibility for the final version of the manuscript.

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