Article

Nursing Ethics
1–10

10.1177/0969733014564104
nej.sagepub.com
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Fear, danger and aggression in a Norwegian locked psychiatric ward: Dialogue and ethics of care as contributions to combating difficult situations

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Abstract

Background: Fear and aggression are often reported among professionals working in locked psychiatric wards and also among the patients in the same wards. Such situations often lead to coercive intervention. In order to prevent coercion, we need to understand what happens in dangerous situations and how patients and professionals interpret them.

Research questions: What happens when dangerous situations occur in a ward? How do professionals and patients interpret these situations and what is ethically at stake?

Research design: Participant observation and interviews.

Participants: A total of 12 patients and 22 professionals participated.

Ethical considerations: This study has been accepted by the Regional Committee for Medical and Health Research Ethics in Norway.

Findings: (a) Both atmosphere and material surroundings were interweaved within dangerous situations, (b) the professionals applied stereotypes when interpreting dangerous situations and (c) the professionals and the patients had different interpretations of what triggered dangerous situations.

Discussion: The discussion centres on how care ethics and a dialogical practice might contribute towards combating difficult situations and the ways in which change is an ongoing ethical process of becoming.

Conclusion: The ethics of care and a dialogical approach are suggested as ethical frameworks for preventing fear, danger and aggression in psychiatric wards. Both frameworks can be understood as patient-driven, including the relational and contextual perspectives. It means a shift from professionally driven processes to patient-driven dialogue.

Keywords

Aggression, dialogue, empathy, ethics of care, fear, fieldwork, patients, professionals, psychiatry

Introduction

This article focuses on situations in a Norwegian locked psychiatric ward where fear and aggression are part of the daily life of both professionals and patients. Aggression and violence against healthcare staff

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are a global problem.[1] The fear of being physically harmed and concerns about doing harm or damage to patients are reported by nurses in Italy, the United Kingdom and Iran.[2–5] These studies show how a working environment where there is a potential for danger can have a damaging impact on patient care. Moreover, physical, emotional and psychological violence are expected by nurses working in acute mental health facilities.[6–8] The studies exposed fear as the precursor to violence and aggression, and fear was experienced by both patients and nurses.[9]

A general distrust in patients is revealed as a typical phenomenon among psychiatric nurses working in an acute psychiatric ward.[10] A more specific distrust among professionals is related to the patients' diagnoses. Patients with a dual diagnosis are more likely to be expected to be violent.[11]

Different studies emphasise environmental factors (e.g. locked doors, overcrowding, lack of privacy, lack of activities) and intra/interpersonal phenomena (e.g. type of nurses, unmet client request, staff behaviour) as triggers for aggression and violence.[1,5,7,8,12]

A qualitative study found that nurses had two kinds of interpersonal attitudes towards aggression, represented by the images of a ballet dancer and a bulldozer. The ballet dancer signalled a caring approach, implying that the helpers put themselves in the patients' shoes; the bulldozer approach mirrored the patients as an object that could be controlled.[13] Attitudes towards aggression also seem to belong to individuals among staff, rather than to a ward culture.[14]

In order to reduce aggression and violence, a study of medical and nursing staff highlights the importance of professionals who are able 'to tune in more deeply to the reasons behind a patient's aggressive behaviour', and to use alternatives to seclusion and restraint in order to humanise patient care (p. 65).[15]

A survey study comparing the attitudes of staff and patients in a general acute mental health service facility shows that both groups agreed on the potential value of medication, and both tended to disagree that prescribed medication could lead to aggression. Both groups believed that seclusion could be a helpful strategy, but patients tended to believe that it was overused, as compared to staff.[1] Quirk et al.[16] shed light on how service users themselves take an active role in making a safe environment for themselves because they cannot rely on staff to do so for them.

The study states that the current evidence overwhelmingly reflects on the professionals' perspectives of risk management and that there is little evidence as to how service users are able to manage the risk they face or pose to others.[16]

When aggression and dangerous situations occur, the ethical issues at stake can be explained in terms of ethical theories such as utilitarianism and deontology or the ethical principles of beneficence, nonmaleficence, justice or respect for autonomy.[17] Our focus, however, is more in line with *care ethics*,[18,19] emphasising empathy and dialogue – keywords that will be addressed in section 'Discussion'. To be treated respectfully as a unique person even in dangerous situations may calm things down and prevent harm. Opposite, to be met in a rigid manner may provoke aggression and make the person feel even more vulnerable and helpless. With this in mind, we will highlight the healing elements in dialogical practices and 'change as an ongoing ethical process of becoming' outlined by Bøe et al.[20] They address the Russian philosopher Mikhail Bakhtin (1895–1975) when they state that mental health therapy is ethical by nature and that *change* is a keyword in therapeutic practice and dialogue as an ethical event (p. 20).[20] People should not be conceived of as being in a fixed state – in our case by the label 'dangerous people'. Instead, focus is on the context and the interplay, with emphasis on the ethical event of *becoming*. Thus, it is an ethical imperative to explore and reflect upon what is going on *between* the helper and the patient.

The well-known ethicist Seyla Benhabib[21] thinks somewhat along the same line. She differentiates between the *generalised* and the *concrete* other. The first refers to the individual's formal rights and duties, while the latter focuses on the individual as a human being with a concrete history and identity. Both belong to the area of ethics and complement each other, although the latter requires love, care, sympathy and solidarity according to Benhabib. She introduces *a communicative ethics of need interpretations and the*

relational self (p. 415)[21] as a moral framework, in which the dignity and worthiness of the generalised other are recognised through 'an acknowledgement of the moral identity of the concrete other' (p. 416).[21]

Recognising the person as an individual with formal rights and caring for him or her as a concrete, unique other imply that the person is not treated as a stereotype, but is understood as being in a state of becoming. It means that both physical surroundings and the way in which the person is met by professionals may enhance safety and dialogue or, on the other hand, trigger aggression and fear.

Although not exactly the same as *communicative ethics of need interpretation*, dialogical practice has proved effective when combating difficult situations, such as psychotic crises.[22,23] In many respects, this is a radical perspective within locked psychiatric wards, because it means a shift from professionally driven processes to dialogues driven by patients, in which the task of the professionals is mainly to adapt to a way of life and to a way of being, using a language to which patients are accustomed. With dialogical practice, the most important factor is to respond to the patients' statements and opinions.

According to Bakhtin, dialogue is not merely a means of communication, but the way in which human beings form themselves in relation to others and to their surroundings. This is the very first thing we learn in life. Bakhtin[24] wrote, 'authentic human life is the open-ended dialogue. [. . .] Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth' (p. 293).

A person does not learn something new if he or she is afraid or if she or she feels overlooked and left without a response. Essential in relational practices is responsiveness, safeguarding that the persons are heard and responded to. However, it requires that the helper is present at the very moment, not only 'as a professional person' but also as a human being. This takes courage, and the main factor to improve change in dialogues is to create a dialogical space here and now. Thus, conversation is unique and should guide our genuine curiosity and openness towards each other in the session.

Our study focuses on both professionals and patients and attempts to analyse what happens in a ward where fear and aggression are part of daily life. It must be said, however, that the professionals' opinions are given more space due to the fact that they more frequently have been involved in or discussed dangerous situations. By examining everyday life in a locked, psychiatric ward, we gain in-depth knowledge by using information directly from those who are present in these wards. We aim to emphasise what happens when dangerous situations occur and how they are handled. We also aim to analyse both from the perspective of the professional's understanding of a dangerous patient and from the perspective of how the patients understand themselves. We will discuss whether a dialogical practice may be utilised to combat dangerous situations. The research questions are as follows:

- What happens when dangerous situations occur in a ward?
- How do patients and professionals interpret these situations and what is ethically at stake?

Fieldwork

Setting

The locked psychiatric ward, situated in a middle-size Norwegian town, has the capacity to treat nine patients at a time. All patients have single rooms with a private bathroom. The front door is locked, but patients may use two protected courtyards. All the staff members carry security alarms.

Data collection

The researcher T was responsible for data collection, carried out through participant observations and conversations/interviews with staff and patients throughout a period of 4 months in 2010. By studying

the staff and patients in the locked ward, it was possible to gain an in-depth insight into their experiences and actions.[25–28]

The ward was visited 48 times, on average three times a week from 2 to 7 hours each time, daytime, evenings and two nights. A mixture of spontaneous conversations with patients and staff, and observations of actions, was recorded immediately afterwards the same day. T observed at close hand how and where people interacted. Spontaneous conversations with staff and patients often arose in these situations. Quotes from the employees are based upon one-to-one spontaneous conversations or interviews. A total of 18 planned one-to-one formal staff interviews were carried out. Quotes from patients mostly come from one-to one spontaneous conversations after T had spent time getting to know them. It was difficult to plan formal interviews with patients, because their condition often changed rapidly. T found it ethically right to make contact with the patients in a careful manner by mingling with them in a natural, spontaneous way. Field notes were structured by recording speech and action in one column and T's reflections in another, thus making reflections a part of data. The compilation of these data formed the basis for further questions and exploration with new interviewees, the so-called snowball-effect.[29] Moreover, in this way the researcher could check with patients and staff to ensure that her recordings were an accurate reflection of their views. Therefore, data collection was an evolving process, not made by a fixed, structured interview guide. New questions were guided by previous observations and interviews.

The participants

T presented herself in a careful manner when recruiting patients and staff. She was always open about her role as a researcher and found that patients were perfectly able to distinguish between her and the staff. Altogether, 12 patients, 9 men and 3 women, participated in the study. They had different diagnoses, such as schizophrenia, bipolar disorders, personality disorders and substance-induced psychosis. The youngest was 17 years old and the eldest 53 years. Altogether, 22 employees, 14 men and 8 women, aged between their mid-20s and early 60s agreed to participate. Some were trained nurses with or without specialisation in psychiatric nursing, while others were social health workers. All were called milieu therapists. Two psychiatrists also took part in the study, as well as a few employees on short-term contracts without formal training. Because of confidentiality, we will not differentiate between the staff in the presentation, but just call them 'staff' or 'professionals'. All informants gave written voluntary, informed consent. No consent was withdrawn. Patients who were not asked or did not give consent are not included in the results. On one occasion, T took notes at arrival when the patient was not able to consent. This patient gave consent in retrospect.

Analysis

The field notes and interviews consisted of 200 pages of text. First, in order to gain an overall impression, field notes and interview transcripts were examined carefully by the researcher who made the data collection. All situations, episodes and expressions relating to (a) dangerous situations in the ward and (b) how they were interpreted were identified. These data were delivered to the co-author who questioned how these situations were experienced by patients and professionals. Having a co-author with no acquaintance of the informants to review the data appeared to be beneficial, as she was able to view data at a distance. Together, both authors attempted to detect patterns, themes, repetitions, contrasts and paradoxes in the material.[30] The process of condensation made it possible to identify three themes, namely: (a) dangerous situations are interconnected with atmosphere and material surroundings, (b) dangerous situations are interpreted by using stereotypes and (c) different triggers make different situations dangerous.

Ethical considerations

The Regional Committee for Medical and Health Research Ethics in Norway accepted the project (2010/1103). All participants in the study consented to participation. However, it is problematic to ask people who are involuntarily committed to a medical health facility to take part in a study. It is vital that they do not feel obligated to participate. For the researcher, it was important to act carefully and with respect. If the atmosphere was relaxed and confident, T found it natural to take part in different activities or ask for a chat. If not, she retreated. Regarding confidentiality, all participants are anonymous.

The validity of the study

Participants' experiences are quoted by using their own descriptions of different situations. In this regard, definite settings about fear and aggression are illuminated. Nevertheless, T chose situations or persons to interview, a potential bias of which she had to be aware. Moreover, a field researcher is not able to guarantee that her presence will not influence participants' behaviour or narratives. However, keeping in mind the duration of the fieldwork, it seemed that the participants became familiar with the situation, even more so because there was a constant flow of new people, for instance students and employees on short-term contracts.

Results

When the staff thought dangerous situations may occur, the atmosphere in the ward was marked by fear. Preparations were made to restrain and seclude patients. Aggressive female patients, without psychosis and who had not been sexually abused, and patients described as 'selective sociopaths' seem to be those who cause most provocation and illustrate how the staff use stereotypes to define provocation levels among the patients. Triggers can therefore be found in the atmosphere and material surroundings, and they are related to stereotyping as well as gender.

Atmosphere and material surroundings

When a researcher is present in the ward, he or she relates to other people present and to material surroundings. Additionally, he or she also becomes a part of the atmosphere of the place. T sometimes experienced a kind of electric atmosphere in the ward when the professionals were expecting the arrival of a patient they knew had been aggressive before. The restraint bed immediately became part of this electric atmosphere, although the bed was not usually visible to the patients and not in use very often (three times during the research period). Nevertheless, it was present in the language as an advantageous instrument with which to control the patients. One milieu therapist (MT) said, 'It is better for both us and the patients to use the bed instead of struggling, trying to hold them'. The restraint bed was used as a verbal threat against the patients and as a stick behind the door: 'I told him that if he as much as tries, I will pick up the restraint bed immediately'. The restraint bed was also used as a physical object to remind patients and professionals about a potential danger. Another MT described mechanical restraint as a necessity, representing safety and convenience:

> It's never OK to restrain [. . .], but it is necessary. Personally, I would prefer to spend more time waiting. Sit down, use dialogue. [. . .] Some [patients] find it good to be restrained, being controlled. [. . .] It is wonderful, having them restrained. Then we don't need to ask for more people all the time. We have to distinguish between punishment and restraining.

Some of the patients felt that restraint could be avoided. A young woman, for instance, told about an incidence she found humiliating. She was picked up by an ambulance and her head was held down in such a way that it hurt badly. She was put in restraints, and the belts were tightened so hard that it was painful. In retrospect, she believed such treatment was unnecessary because she had gone willingly with the people present. She was not able to take care of herself and agreed that forced hospitalisation was necessary, but it was the way in which the whole thing was done that was offensive – like being held down and put in belts. She said, 'The locked doors are not so bad. The really bad thing is to be held, when they use force against my body'. Another patient said, 'Once they put me in belts, but the situation could have been avoided with a cup of coffee and someone to talk to'. 'Hell' was a word used to describe the seclusion area: 'When you don't understand why, it's like going through real Hell [. . .]. It means restraints might trigger your paranoia'. Forced medication was also experienced as a kind of restraint: 'I feel like I'm in chains, convicted for life without law and judgment'.

For the staff, the seclusion area became a place where threatening situations could be calmed down. Access to this area was through a locked front door, outside the main ward. The seclusion area was divided into two parts. The largest section was stripped of all furniture except a table, a couch and some chairs. There were also two bedrooms, also stripped except a bed, a chair and a bedside table. One MT described the advantages of the seclusion area:

> If we take everything away, they recover more quickly. We have to seclude. One patient had destroyed a lot of his things and he gets so sad about it [. . .]. Once, a patient hit me because I took away his favourite book. But we saw he pulled himself together when everything was taken out.

Patients, on the other hand, did not always feel comfortable in the seclusion area. They talked about the room as dehumanising. Although they felt that seclusion was necessary for a while, they thought the naked room was of no help. A male patient said that 'after a while it only makes you feel worse'. Another added, 'They could have considered letting me have something to do there'.

The fear experienced by the professionals was reduced by having the possibility to calm down patients by the help of the restraint bed or the seclusion area, while some of the patients describe these situations as provoking aggression. It seemed that the tools the staff used to calm down the patients could make some patients more afraid and aggressive.

Stereotypes

The professionals appeared frequently to use stereotypes when interpreting dangerous situations. When the professionals discussed violent patients, it was mostly in terms of *them* than *he* or *she*. This use of the word *them* was to refer to 'the bipolar', 'the personality disorders', 'the selective sociopath' and 'the substance-induced psychosis'.

At other times, the MTs were heard to discuss an individual, aggressive patient as follows: 'He has all the personality disorders you could imagine'. One member of staff said about a patient:

> He has a sociopathic personality disorder. In fact he is really small; he is constantly taking your measure. If you retreat, he takes you. You feel a little bit more for some than for others. But we have negativistic pricks, regardless of how positive you try to be. It hurts you.

However, the professionals did not always perceive patients in the same way. One patient could be interpreted as a selective sociopath by one professional, but differently by another. Despite this difference of opinion, the professionals influenced each other in the way in which they spoke about and discussed the patients among themselves. Some professionals seemed to agree more than others, for instance, in describing a patient

as a sociopath. It seemed that they continuously informed and supported each other and as such reinforced their opinions about patients. Professionals working the same shifts displayed important aspects of these dynamics. Professionals working other shifts did not use the word 'sociopath' about patients.

The patients disliked being grouped by diagnosis. One young man said that 'they always forced you into a diagnosis', and a middle-aged woman said 'the doctors don't think about the individual person'. Another patient said, 'He [the doctor] diagnosed me as psychopathic [. . .]. I felt like I'd been hit to the ground and I was bloody furious'. On another occasion, the researcher heard a discussion about a patient the staff believed to be dangerous. When she expressed a desire to talk with the patient without the protection of a 'bodyguard', she was seen as naïve. The psychiatrist said the patient was too ill for a chat with the researcher, but the patient really wanted this talk to get rid of his frustration. He said, 'Why would I attack someone from outside the system?' meaning he admitted he could be dangerous, but according to him it had to do with who was present.

Although the professionals interpreted the patients differently, stereotyping them according to specific diagnoses was a way of labelling them as dangerous or not. The stereotyping sometimes helped them plan strategies to avoid situations where patients acted out. The patients, however, wanted to be met as individuals, and they believed this would help them to calm down.

Triggers

The professionals and the patients interpreted dangerous situations differently and were triggered differently. For the professionals, it could be when patients spat on them and threatened them verbally. The patient's gender combined with a specific diagnosis was also one of the triggers. A non-psychotic and aggressive woman triggered them more than a psychotic woman who had been abused because the former was interpreted as calculating and the latter as without guilt.

For the patients, the triggers could be being picked up by uniformed police officers: 'I don't understand why they need all these uniformed policemen? They have taken me to the hospital a lot of times. They provoke me more with the uniform. Why can't they dress ordinarily and sit in the ambulance?'

Other triggers for the patients could be forced medication, the staff's attitude, male professionals and strict house rules. One patient explained what made him angry:

> No, it was not the restraints; it was the denial of the coffee and cigarettes which for me reduced my anxiety. Not being allowed to follow my own routines made the anxiety escalate dramatically because I could not smoke. Just as well I didn't get medication for my anxiety which has been extreme.

The nights were the most difficult periods for the patients. Night-time was 'no-time' implying they were denied, for example, coffee, cigarettes, going out or taking phone calls. Being controlled by others triggered the feeling of powerlessness and was also a provocation. Medication could be a trigger as well as cessation of medication:

> I had a really bad doctor. There was no contact at all. He took away the Zyprexa even when he knew I needed them. He said I did not need them because I was psychopathic. I went to our cottage and the feeling that my head was filling me up with thoughts increased. I also had hallucinations; I saw my mother burning outside the windows. I needed that medication. I don't know what went wrong but I visited the emergency ward, showed them a knife and threatened to kill the people in the ward.

Triggers might also be associated with mental problems: 'I hear terrible voices inside my head all the time, especially in the evenings. I keep away from the common areas to avoid going crazy', one patient said.

He also said he felt he could read people's thoughts, and these thoughts made him so angry he sometimes smashed the furniture.

When female patients displayed what could be interpreted as a non-typical female attitude, the professionals seemed more provoked than if the patients conformed to their image of what is female and non-female. Factors that triggered the patients sometimes made the professionals less scared. Both the physical absence of objects in the seclusion area and the bed with the Swedish belts were seen as a professional way of handling dangerous situations. These objects, however, were triggers for quite a few of the patients.

Discussion

The findings show what happens when dangerous situations might occur and illustrate that different professionals and different patients have various interpretations of such situations. No one wanted dangerous situations to happen, so the question is how to avoid dangerous situations in a locked ward? To answer, we draw attention to (a) *the ethics of care* and (b) *the dialogical approach* and consider whether this might be a professional attitude that may help reduce threatening and violent episodes.

Care ethics recognise the vulnerability and interdependency of both the helper and the patient, emphasising reciprocity and empathy.[18,19] If the first thing a patient meet when admitted to a psychiatric ward is seclusion or a threat of being put in restraints, he or she may feel even more vulnerable, helpless and angry. We believe that being welcomed in an empathic way is crucial. One may ask, is it naïve and unrealistic to promote empathy and *a communicative ethics of need interpretations*[21] as a moral framework when the helper is spit on and threatened verbally and perhaps physically? Our findings indicate that such situations can be avoided by reducing the triggers, for instance, making no-time into yes-time, avoiding uniformed police, minimising forced medication and creating an empathic atmosphere. Recent research documents, for example, that seclusion in psychiatric wards may be avoided by the staff's attitude the first 5 min at admission by changing the nurses' attitudes.[31] The researchers argue that care ethics requires 'a new way of thinking and acting, resulting in new relationships between nurses and patients' (p. 766).[31]

A dialogical approach may add some more understanding to what a new relationship between staff and patients might be. It is more than just talking together. It implies a shift from professionally driven processes to a patient-driven dialogue which may contribute to trust and safety *before* the dangerous situations occur and things tend to escalate. This shift is supported by research that states the advantages of professionals 'putting themselves in the patients' shoes' – having a ballet dancer attitude[13] and 'tuning in more deeply to the reasons for patients' aggressive behaviour' (p. 65).[15] The importance of professionals adapting the way of life and behaviour to a language to which patients are accustomed has been underlined. When one of the professionals said she would prefer to use dialogue and try to sort out what happened instead of quickly secluding a patient, her approach highlights the importance of tuning in and is supported when the patients talk about the importance of being understood as individuals.

But how can you be a dialogical professional when you are afraid? This is a challenge, but the findings give some direction. Primarily, a dialogical approach is incompatible with stereotyping of patients. Thus, we may be able to learn from and carry out more research on who and what is not stereotyping the patients. A non-stereotyping attitude is a matter of humanising patient care and does not combine well with the bulldozer approach that mirrors the patient as an object to control.[13] Mirroring the patient as a subject means you have tuned in using words that conform to the patients' opinions and statements. However, the staff's interpretation of fear and aggression is most often understood as something inside the patients – as something essential belonging to the disease, reflected, for example, in the label 'selective sociopath'. This constitutes a lack of response to the concrete other[21] and may result in escalation of a dangerous situation. On the other hand, some of the professionals and quite a few of the patients interpreted fear and aggression as something that happened because of how and where they were treated – as relational and contextual (e.g. the

police, the lack of a chat, the restraints and the seclusion area). With a dialogical perspective, generating safety will involve the material surroundings as well as the attitude of the professionals. Moreover, the surroundings should support dialogue, allowing one person to open up towards the other. This implies that the professionals cannot claim that 'they' need to be in surroundings stripped of furnishings, but rather have surroundings that the patient's wishes. Providing some form of activity in a seclusion area might, for example, support a mutual conversation where the patient is respected as a human being with individual needs and not mainly as an aggressive sociopath. It is tempting to say that women should mainly be the ones present when aggressive patients arrive because some of the men are described as provoking more aggression. We believe that both female and male professionals could take a dialogical approach. Their task would subsequently be to generate safety by responding to the patients' opinions both in terms of material surroundings and relationships supporting a dialogical attitude. Nonetheless, this is not a simple process. It takes courage to move beyond the comfort zone. Bøe et al.[20] write that it 'implies a shift from speaking of *who we are*, to speaking of *the way we constantly become*' (p. 19). This is indeed an ethical choice.

Conclusion

We have illustrated how fear and aggression can create dangerous situations in locked psychiatric wards and that these situations are associated with relations and material contexts. To prevent danger and harm, it is an ethical obligation to provide supportive material surrounding as well as a non-provoking, including atmosphere. Triggers should be minimised and stereotypes avoided. We have to be aware of professionals and patients as relational human beings interconnected to a material world. The ethics of care and a dialogical approach are suggested as ethical frameworks for preventing fear, danger and aggression. Both frameworks can be understood as patient-driven, including the relational and contextual perspectives. It means a shift from professionally driven processes to patient-driven dialogue.

Conflict of interest

The authors declare that there is no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

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