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Self-Determination Theory: A Framework Well Suited to Informing Research of Adverse Inpatient Mental Health Experiences

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ABSTRACT

Contrary to the expectations and intentions of inpatient mental healthcare, reports of adverse experiences by people admitted to inpatient settings are common and on the rise. Such experiences negatively impact individuals' mental health and recovery and incur costs to their networks, mental health providers, the healthcare system, and society at large. Research indicates ongoing challenges in understanding and addressing the complex interplay of factors that contribute to a diverse range of adverse experiences, from seclusion, restraint, and coercion, to boredom, loneliness, and lack of therapeutic relationships. There is a pressing need to better understand the mechanisms of adverse inpatient mental health experiences and identify frameworks to aid in more efficient and effective translation of knowledge into practice. This paper proposes self-determination theory (SDT) as a framework that can assist nurse researchers and practitioners elucidate the nature of adverse experiences and guide developments to mitigate adverse outcomes. Critically, SDT prioritises human psychological needs and wellbeing, and thus has potential to inform rights-based, person-centred, recovery-oriented research and development. This paper provides an overview of recent literature on adverse experiences before introducing SDT. It then considers adverse inpatient mental health experiences through the lens of SDT, providing actionable guidance for nursing research and development.

Introduction

Everyone has the fundamental right to humane, person-centred, recovery-oriented mental healthcare (United Nations, 2017). This implies all nursing care should be delivered with compassion, dignity and understanding that supports positive change. Globally, inpatient mental healthcare settings and mental health providers, inclusive of nurses, are expected and arguably intend to deliver such quality care (Hall, 2019; Oates, 2017). Yet despite this, a significant number of people admitted to inpatient units report having experiences that are stressful, unsafe, distressing, harmful, threatening, traumatising, or detrimental to their mental health and recovery journey (Akther et al., 2019; Hennessy et al., 2023; Mangaoil et al., 2020; Staniszewska et al., 2019; Thibaut et al., 2019).

Recent decades have fortunately seen steady growth in research from a range of disciplines investigating phenomena related to adverse experiences in inpatient mental health settings. What were once taboo, ignored, denied, and actively defended are now more widely acknowledged. However, reports of adverse inpatient experiences continue, and are anticipated to present ongoing challenges due to the projected increase in demand and use of inpatient services due to a global rise of mental ill-health (Wu et al., 2023). Such circumstances make research to better understand the mechanisms of adverse experiences in inpatient mental health settings and the development of new practices to lower such experiences every more pressing. To these ends, researchers have noted the need for frameworks to aid in synthesising existing evidence and inform future studies (Beames & Onwumere, 2022; Gooding et al., 2020).

One theory well-suited to respond to these needs is self-determination theory (SDT). SDT is a macro-theory of human motivation, personality, and wellness, initially developed by psychological theorists Richard Ryan and Edward Deci (2000). In the context of adverse inpatient mental health experiences, it provides a comprehensive theoretical framework that can inform research seeking to enhance our understanding of adverse experiences and guide the design, delivery, and evaluation of new inpatient mental healthcare practices. This paper provides an overview of recent review literature concerning adverse experiences, followed by guidance on how SDT may be used to inform research examining adverse inpatient mental health experiences.

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Adverse inpatient mental healthcare experiences

A growing body of literature describing adverse inpatient mental health experiences has evolved from capturing lived experiences to investigating contributing factors and the design and evaluation of interventions. What is clear is that a broad range of experiences can result in adverse outcomes. Nurses and allied health providers use of seclusion, restraint, and coercion, inclusive of involuntary admission, are the most reported incidents associated with adverse experiences (Akther et al., 2019; Mangaoil et al., 2020; Sugiura et al., 2020). However, less overt experiences and conditions in inpatient settings have also been found to lead to distress and harm and compromise recovery. For example, boredom and frustration can result from a lack of activities (Staniszewska et al., 2019), while a lack of information about diagnosis, treatment, rights, and choices can leave patients feeling powerless and without autonomy (Akther et al., 2019; Sugiura et al., 2020). Furthermore, patients regularly report detrimental effects due to feeling disconnected from the outside world, insufficient social connection, or peer conflict within inpatient settings (Staniszewska et al., 2019).

Therapeutic engagement and the quality of relationships with staff is a particularly potent and common factors in reports of adverse experiences. Components of care such as nursing staff's availability, negative staff attitudes, and the use of restrictive practices often foster patient stigma and demotivation, disrupting the formation of therapeutic relationships (Cusack et al., 2018; Lessard-Deschênes & Goulet, 2022; Skar-Fröding et al., 2021; Staniszewska et al., 2019; Woodward et al., 2017). Of relevance is Hawsawi et al.'s (2020) qualitative review of staff and patient perspectives regarding seclusion and restraint, which found that staff also experience disruption in therapeutic relationships following the use of such interventions. Such findings are a reminder that interventions that result in adverse outcomes for individual patients, often also cause negative ripple effects impacting staff and other patients in the vicinity of such actions.

While it is a given that there is subjective variation between people's experience of adversity in inpatient settings—with not all people reporting adverse experiences, in their review of patient experiences of chemical restraint, Muir-Cochrane and Oster (2021) also found within-individual variation in adverse experiences. That is, some individuals who reported chemical restraint as adverse also acknowledged that, in retrospect, they could see it was also necessary and a better alternative to other potential interventions. While such responses do not negate their initial experience of harm, they highlight the complex and, at times, contrary perceptions individuals may hold about their experiences, adding to individual variation.

Much of the review literature also emphasises overarching factors that lead to adverse experiences. For instance, Hallett et al. (2023) synthesised qualitative data from 111 studies across 25 countries, developing a conceptual framework of the key factors contributing to adverse outcomes. These factors were the ecosystem (physical environment, resources, and other people), the systems (treatment interventions and processes surrounding admission, transfer, and discharge), and the individual (personal autonomy and trauma history). The framework aims to enhance understanding of the spectrum of adverse experiences and provide some direction as to what interventions will be most effective to mitigate adverse experiences.

Factors relating to the environment, interventions and processes, and patients, were also identified in other systematic reviews with different areas of focus, such as Beames and Onwumere's (2021) exploration of risk factors associated with coercive practice; Hennessy et al.'s (2023) investigation of factors associated with individuals' experiences of re-traumatisation; and Modini et al.'s (2021) meta-review of patient perceptions of inpatient care. Systematic reviews of existing interventions across a variety of adverse experiences also reflected the multifactorial nature of adverse experiences (Dickens et al., 2022; Giacco et al., 2018).

Of note is the recognition of the role of past trauma in the studies by Hallett et al. (2023) and Hennessy et al.'s (2023) research teams. It highlights that factors beyond the immediate inpatient setting also shape individuals' perceptions and experiences. In a similar vein, Aluh et al. (2023) looked at factors "Beyond patient characteristics" that influenced involuntary admission in mental health care. They identified aspects of the mental health system but also factors in the broader social system, including mental health legislation, economic recession, and public attitudes towards mental health, as influential contextual factors in the occurrence of adverse experiences. Subsequently, they assert the need for a multi-modal approach to reducing adverse inpatient mental health experiences.

This selective and cursory overview of review studies firstly reveals a considerable body of knowledge on adverse experiences within inpatient mental health settings. However, it should be noted that in many cases, studies were deemed weak in quality. Regardless, the literature points to a range of adverse experiences and the multiple overarching factors that play a role in the occurrence—and reduction—of adverse experiences. This prompts the question of whether there is a way to understand adverse inpatient mental health experiences that could lead to interventions that successfully mitigate a broad range of adverse experiences reported by patients. This is where a theoretical framework like self-determination theory (SDT) can assist researchers.

Self-determination theory

Basic psychological needs

Given its explicit focus on psychological well-being, a growing number of researchers utilise SDT to investigate phenomena related to mental health (Cheng et al., 2021; Gaine et al., 2022; Mancini, 2008; Perlman et al., 2017; Raeburn et al., 2015). A foundational premise of SDT is that all humans have the inherent capacity to be energised towards growth, curiosity, kindness, and interrelatedness, as well as the potential vulnerability of stagnation, defensiveness, and withdrawal (Ryan & Deci, 2017). According to SDT, whether a person maintains a sense of growth or succumbs to

vulnerabilities lies in the respective satisfaction or frustration of three basic psychological needs: autonomy, competence, and relatedness (Ryan & Deci, 2000).

Autonomy refers to a person's sense of choice and self-endorsement in their actions. When this need is met, people experience congruence between their thoughts, feelings, and behaviour. Conversely, the frustration of this need can leave people feeling coerced, undermining their sense of direction. Competence, captures people's desire to engage effectively and contribute to the environment. Need fulfilment can come through experiences of learning, skill acquisition, and taking on and overcoming challenges, fuelling a sense of efficacy. When this need is frustrated, it can induce feelings of inadequacy and helplessness. Relatedness, denotes people's need for connection, significance, and belonging within social contexts such as family and the broader community. When needs for relatedness are not met, people often experience alienation, exclusion, isolation, and loneliness. SDT posits that these three psychological needs are universal: relevant in all contexts, for all people, regardless of sociodemographic or cultural background, age, or personality (Chen et al., 2015; Lynch, 2023).

Through the lens of SDT and basic psychological needs, adverse experiences can be understood as experiences that frustrate a person's needs for autonomy, competence, and relatedness. The next section outlines major factors that contribute to need frustration (or satisfaction) and illuminates the relevance of these factors to informing studies investigating adverse events in inpatient mental health settings.

The role of the environment

Ryan and Deci (2017) assert that the environment—both built and social—is the central factor in whether people's needs for autonomy, competency, and relatedness are satisfied or frustrated. SDT proposes that there are three broad types of environments: need-supportive, need-thwarting, and need-depriving. Need-supportive environments satisfy people's three basic psychological needs. In inpatient mental health settings, this would translate into to care where professionals actively listen, respect patient perspectives, provide information and offer choice, involve them in their care planning, encourage initiative, challenge patients appropriately, provide positive feedback, and facilitate social interactions. Such environments would be found to make patients feel valued and engaged, enhancing their health and well-being.

Conversely, need-thwarting environments are characterised by controlling features and impede people from getting their needs met. Such environments often involve punishments, rewards, and coercion that pressure people to think, feel, or behave in specified ways (Deci et al., 1996; Williams & Deci, 1996). In inpatient mental health, the use of interventions like seclusion and restraint would be examples of need-thwarting conditions. Design features of the built environment that facilitate monitoring and restriction of patient movements and incentivise selective behaviour, such as centralised nurses' stations and locked doors, may further exemplify such control (Ulrich et al., 2018). Similarly, policies and rules enforced by staff, such as removing the right to dress in regular clothing, restricting visiting hours, limiting physical activity and spaces to move in, denying people access to their phones, or lack of involvement in treatment decisions, may also be interpreted as actively frustrating peoples' innate need for autonomy, competency, and relatedness (Slade, 2017; Sugiura et al., 2020). Often, elements of inpatient care thwart needs due to the prioritisation of risk management strategies associated with a biomedical paradigm of mental health over patient experience (Slemon et al., 2017). Such approaches may enhance feelings of safety and control among service management bureaucracy or staff but do little to satisfy patient needs (Thibaut et al., 2019).

SDT further differentiates need-depriving environments. Unlike the active obstruction of satisfying needs in need-thwarting environments, need-depriving environments are understood to be characterised by the absence or low satisfaction of needs due to passive neglect or oversight (Vansteenkiste & Ryan, 2013). Thus, need deprivation typically manifests where there is a lack of presence and empathic interaction from staff, leading to patients feeling disconnected. Whith reference to inpatient settings this may be characterised as environments where nurses and allied health practitioners spend large amounts of time writing notes and attending staff meetings, decreasing time with patients and their experience of relatedness (Liddicoat et al., 2020). Few activities and opportunities for growth may also precipitate to boredom and frustration, depriving patients of opportunities to foster a sense of competency and connection (Marshall et al., 2020). While need deprivation may seem less detrimental than active need thwarting, in accordance with SDT, people admitted to inpatient mental healthcare likely have histories of not having needs satisfied. Thus, further need deprivation can significantly compound a patient's condition (Vansteenkiste et al., 2020).

Pertinently, SDT further posits, that while environments can be classified as need-supportive, need-thwarting, or need-depriving based on their predominant characteristics, many environments involve a mixture of these three characteristics. An environment may therefore be classified as need-thwarting yet inevitably also have aspects that satisfy needs and support recovery and aspects that are need-depriving contributing to frustration. Importantly, however, at any given moment, an environment is either satisfying or frustrating needs—there is no neutral in between (Ryan & Deci, 2017). Subsequently, in the one environment, a person may experience oscillation between their needs being satisfied and frustrated (Gagné et al., 2018). Pragmatically, SDT asserts that whether an environment or an element in the environment satisfies or frustrates needs, it is not objective nor static but the outcome of the interaction between environment and person at a point in time. A person's prior life experiences therefore become essential in this equation.

The role of prior life experience

According to SDT, over the course of their life each person develops a unique history of prior experiences in

need-supportive, need-depriving, or need-thwarting environments. With reference to inpatient care, such past experiences not only contribute to the psychological conditions necessitating hospitalisation but also influence how patients interact with and respond to care. According to SDT patients with histories marked by need-thwarting environments will be likely to be particularly sensitive if they experience similar elements within inpatient settings. In turn, SDT posits that they are likely to respond with established patterns of compensatory behaviour (such as defensiveness or withdrawal) and seek need substitutes (validation and praise) (Ryan & Deci, 2017).

A common pattern in inpatient units is for patients to respond with superficial compliance or dependence on relationships in line with their past experiences (Lowe & DeVerteuil, 2020). Concurrently, need-supportive features of the same inpatient environment may go unrecognised by patients given a lack of experience with such support, making it challenging for staff to fulfil needs. Moreover, prior experiences also shape patients' goals and aspirations regarding their mental health recovery journey and influence their motivational orientation. Amotivational or extrinsic motivational style—and a lack of intrinsic motivation—is typical of those accustomed to need-thwarting environments. This is likely to make it hard for people to sustain behaviour's and draw on the potential benefits of supportive environments (Kremen et al., 2016; Van der Hoogt, 2021).

Such adaptive responses based on past need frustration may provoke staff and the wider system to behave consciously or unconsciously in ways that maintain or increase need-thwarting or need-deprivation. This interaction between patients and staff may perpetuate cycles of need-thwarting behaviour's, a phenomenon described by SDT's founders, Ryan and Deci (2017) as transactional influence. For example, a patient's defensive refusal to participate which stems from a learned protective measure against perceived control, may incite nursing staff to employ restrictive measures, further entrenching the patient's distress and coping strategies. Alternatively, in another example, nurses may keep their distance from a silent and withdrawn person.

What is more is that these interactions often become cyclical and may lead nurses, doctors and allied health professionals to escalate responses over time, moving from, for example, warnings to removal of privileges to the use of seclusion or restraint. Such transactional cycles lead to a therapeutic bind which create significant challenges for staff (Chieze et al., 2019; Doedens et al., 2020). SDT also prompts consideration of how prior experiences of nurses and other staff also come into play in this context. Such considerations are particularly essential for individuals who have had histories of trauma and may be susceptible to retraumatisation due to coercive practices (Hennessy et al., 2023). Understanding and reforming such transactional cycles is crucial for transforming patients' experience in inpatient settings, mitigating harm and distress, and enhancing their recovery journey.

The factor of prior life experiences is the primary source of individual variation in reports of adverse experiences in inpatient mental health. However, just like the environments being variable in their need-related features, individuals also show variation in how they view and respond to the inpatient setting based on their prior experience. The time of admission, when patients are transitioning from the world into the hospital, is a particularly salient time point when staff may witness the influences of prior experiences and how they have shaped an individual's views, expectations, and desires for their hospital stay. Some may view admission as an opportunity to learn skills to manage their mental health. However, others may interpret the transition into an inpatient unit as an ongoing failure of their capacities and competencies. For one person, leaving family and community may compromise their need for relatedness, while for another, it may bring relief as they get to be with other people experiencing similar mental health issues. Such responses are likely born out of comparison to prior experiences. Thus, using an SDT lens to understand individual's initial views and attitudes towards care can reveal much about prior experiences and current psychological needs assisting research of care practices.

The role of pervasive contexts

Another SDT concept relevant to investigating adverse inpatient mental health experiences is referred to as the pervasive context. It refers to the broader socio economic, political, and cultural contexts, in which a person resides. SDT suggests that the pervasive context entails features that support, thwart, or deprive basic needs and can have a powerful influence on people's experience and subsequent mental health.

According to SDT, pervasive contexts operate through immediate, proximal contexts, enacted often unconsciously by what Ryan and Deci (2017) call socialising agents. In inpatient settings, mental healthcare professionals embody these agents, implementing treatment approaches, policies, and procedures reflective of knowledge, beliefs, and values formed in the broader social systems. Additionally, the broader societal context also shapes patients' previous experiences with and attitudes towards mental healthcare and inpatient settings, affecting their self-perception and responses to treatment and care. SDT suggests that all such factors should be considered as potentially contributing to adverse inpatient mental health experiences.

One modern pervasive context relevant in most inpatient settings is the biomedical model. In most contemporary inpatient services it frames mental health and illness primarily through a medical lens and dominates both the general healthcare system's approach and public perceptions of mental health. This model heavily influences the basis of the training for nurses, doctors and allied health professionals, making biomedical perspectives a significant influence on clinical environments. This influence is evident in how patients are assessed, the types of interventions used, and even the attitudes of the staff, regardless of any recognition of the importance of person-centred and recovery-oriented approaches. Consequently, SDT suggests that adverse experiences in mental health care may often stem from this overarching, pervasive biomedical context.

The concept of pervasive contexts may be particularly valuable to researchers as it can provide a basis for understanding the experiences of people from minority and marginalised populations (related to ethnicity and race, gender, or sexuality), who often face systemic need-thwarting and need-deprivation. The pervasive context, therefore, holds heightened significance for such individuals, potentially exacerbating adverse experiences within inpatient settings. A lack of awareness or acknowledgment of these factors and the presence of stigmatising and discriminatory practices in inpatient settings could further alienate and distress individuals from these groups. This potential impact of pervasive contexts is perhaps already reflected in the disparities and challenges found in mental healthcare settings for minority and marginalised populations. For example, individuals from racial minorities are more likely to be admitted involuntarily to inpatient mental healthcare than non-minority counterparts with similar psychopathology (Australian Institute of Health & Wellbeing, 2022; Barnett et al., 2019; Edbrooke-Childs & Patalay, 2019) and more likely to be physically or chemically restrained (NHS, 2022; Smith et al., 2022).

By drawing our attention to pervasive contexts in inpatient settings, SDT further clarifies the factors that foster conditions in which adverse experiences occur. With this knowledge, inpatient services can gain greater clarity regarding how to create and maintain environments that support rights-based, recovery-oriented practices that work towards restoring all people's sense of relatedness, competency, and autonomy.

Applying SDT when researching adverse inpatient mental health experiences

SDT can assist researchers to understand the nature and mechanisms of adverse mental health inpatient experiences and subsequently develop interventions to reduce the occurrence of such experiences. Drawing on SDT, this paper posits that adverse experiences are less likely to occur when environments satisfy and simultaneously do not thwart individual's basic psychological needs for autonomy, competence and relatedness. This dual focus holds the potential to effectively reduce adverse experiences. Given nurses are at the frontline of service delivery, nursing research is critical to establishing such need satisfying environments. Nurses are often well placed to undertake critical research of inpatient settings they work in.

SDT has potential to inform studies exploring how mental health inpatient units satisfy, thwart, or deprive consumer's needs for autonomy, competence, and relatedness. Such investigations could consider features of the physical setting; norms, rules and policies; underlying care models; therapeutic interventions; and the attitudes and behaviours of staff and management including appraisal of the beliefs, values, and paradigms—as informed by the pervasive context—that shape daily practice. Findings may produce guidance for potential changes within inpatient settings that can support need satisfaction and reduce need thwarting among patients. Future studies might also experiment with and evaluate specific alterations to the social and built environment of inpatient wards in effort to provide care that better satisfies basic psychological needs.

Recognising the transactional nature of adverse experiences, it is also crucial to consider each patient's historical experiences with need satisfaction and frustration. Analysis of such factors may provide insight into individual variations that exist regarding adverse inpatient experiences. Acquiring patient's prior life experience concerning need satisfaction and frustration may be incorporated into formal assessment processes or nurses may also analyse individuals' histories through the lens of SDT in more informal ways. In both scenarios, SDT's Basic Psychological Need Satisfaction and Frustration Scale (BPNSFS), developed by Van der Kaap-Deeder et al. (2020), has potential to serve as a foundational tool to guide such assessment. However, the scale is primarily designed to facilitate inquiry regarding people's current as opposed to earlier life experience. Notably too, it has not yet been tailored to the domain of healthcare or inpatient settings. Research in both areas is needed with respect to the BPNSFS to maintain the rigorous validity and reliability testing it has undergone in other domains (Van der Kaap-Deeder et al., 2020)

When it comes to study methodologies, SDT lends itself to various approaches. Its' use as a theoretical framework for exploring inpatient experience and understanding adverse experiences is a nascent area. Thus, future studies are needed to using qualitative, quantitative and mixed-methods research designs, as well as reviewing existing studies concerning adverse hospital experiences through the lens of SDT. In all such instances the BPNSFS or adapted versions of it have potential to provide useful structure and guidance.

Importantly, reviews of research investigating adverse experiences in mental healthcare highlight a lack of inclusion of researchers who have lived experience of adverse experiences (Hallett et al., 2023; Hennessy et al., 2023). In line with the broader field of mental health research, studies should aim for increased co-production with lived experience researchers and consumers in effort to reduce bias and magnify the representation of patient's voices in analyses and findings. The inclusion of researchers with marginalised and minority backgrounds and identities (e.g. race, ethnicity, gender) is also vital to address the common under representation of such groups in studies focused on adverse experiences (Hallett et al., 2023).

Realistically, regardless of future research and development of interventions it may be impossible to eradicate adverse experiences due to their inherent complexity. As such, another role for researchers might involve developing restorative and reparative methods to address such outcomes when they occur. Here ideas of restorative and reparative are used in a broad sense, referring to practices that acknowledge the occurrence of adverse experiences in inpatient settings; foster more respectful, humanising relationships between staff and consumers; and repair harm that is identified. The latter practices could result in policy and procedure changes at a systems level or the provision of psychotherapeutic support and debriefing opportunities for

individuals who report adverse experiences. SDT provides language and structure for such restorative and reparative practices. Ideally restorative and reparative practices should be integrated into the daily procedures and protocols or inpatient settings. Nursing research is vital to the development and evaluation of such practices and system changes.

Restorative and reparative practices may also be needed and effective post-hospitalisation. Utilisation of SDT across mental healthcare settings has potential to inform the development of support for individuals' continuity of care across treatment settings. This provides another avenue for nurse researchers to lead the way in enhancing continuity of care through the utilisation of SDT as a framework for researching and addressing adverse experience.

Fundamentally however, the development and effective engagement in restorative and reparative practices requires staff acknowledgment and understanding of the possibility of iatrogenic harm in inpatient settings. Thus, another area for research is the development of educational interventions that explain and raise awareness of why acknowledgement, transparency and vulnerability regarding involvement in adverse experiences is vital if they are to be acted upon and addressed. In this area, the language and structure of SDT may also be useful in the development of educational content, ultimately making the topic of adverse experiences more approachable, supporting nurses and allied mental health staff to better comprehend the nature and mechanisms of adverse experiences.

Overall, SDT is a thus a highly practical framework, suited to various avenues and approaches to research. Viewing both the individual and environment through the lens of SDT and integrating these insights has potential to enable the development of targeted processes, protocols, practices and interventions that promote positive outcomes. SDT offers nurse researchers structure and guidance in relation to investigations concerning both the prevention and reparation regarding adverse hospital experiences.

Conclusion

Reports of adverse experiences by people admitted to inpatient mental healthcare have been a consistent source of controversy, cost and challenge to mental health services and professionals, none more so than nurses who are on the frontline of service delivery. Despite isolated interventions to address adverse experiences, there has been a lack of theoretical frameworks to adequately inform research. This paper proposes SDT as a comprehensive framework capable of informing studies investigating adverse inpatient mental health experiences. SDT provides a vision of what all humans need for psychological wellness and ease, enabling an alternative view of adverse experiences as the frustration of needs for autonomy, competence, and relatedness. With this base, the theory also sheds light on the mechanisms of adverse experiences, as it acknowledges and facilitates the unravelling of the complex transaction between person, environment, and the pervasive context that contributes to adverse experiences. Such clarity has potential to facilitate the development of more targeted interventions to reduce unnecessary and counterproductive distress and harm experienced by individuals.

The main virtues of SDT lie in its potential to account for individual variation and the wide range of adverse experiences reported by individuals, as it provides a means to understand the multifaceted and complex interaction between individuals with inpatient environments. By centring universal psychological needs, SDT asserts a non-pathologizing view of human experience, prompting a reconceptualization and movement towards compassionate, recovery-oriented, person-centred, socially just care. In this way, SDT provides nurse researchers with a useful lens to investigate mental healthcare globally. The principles of SDT also challenge nurse researchers to develop approaches capable for promoting the fulfilment of psychological needs within inpatient mental healthcare. To engage in this area of research requires openness, humility, compassion, and critical reflection. In doing so, nurse researchers can work towards developing supportive and empowering environments that respects individuals' autonomy, enhances their sense of competence and mastery, and fosters meaningful connections and relationships—necessary for individuals' recovery journey and overall well-being.

Self-determination theory

A framework well suited to informing research of adverse inpatient mental health experiences.

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