Beyond witnessing: ethical imperatives in action-research on suffering, victims of violence, and structural harm in mental health systems

Abstract: Qualitative research in mental health often exposes systemic contradictions: the researcher listens to testimonies of harm while institutions demand silence. This paper interrogates the ethical tensions of conducting action-research in settings where mental health care reproduces coercion, erasure, and institutional betrayal. Grounded in a five-year, multi-sited ethnographic inquiry across Spain, Italy, Sweden, and Indonesia -conducted under the auspices of European COST Actions FOSTREN, ReMO, and the author-founded EU BEACON One Health Education action- this study integrates lived experience, scientific fieldwork, and participatory methods. It identifies how dominant legal and institutional frameworks in Europe obstruct accountability by shielding professionals through laws that protect subjective annotations, prevent access to clinical records, and frame complaints as symptoms. Drawing from first-hand documentation of abuse and policy engagement at national and international levels, the paper argues for a shift toward radically ethical, open science infrastructures. It advocates for dynamic, reflexive protocols that empower researchers to respond to harm ethically and structurally-transforming qualitative inquiry from observation into intervention. The work responds to urgent calls from affected persons, professionals, and policymakers to end epistemic violence, improve safeguards, and uphold the principle that suffering must not be rendered invisible for the sake of institutional comfort. In doing so, it proposes a framework for ethically sound, action-oriented, and justice-driven qualitative research in mental health.

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introduction: ethics under duress and the urgency of methodological accountability

Ethics in qualitative research in mental health, especially when situated within high-stakes, politically contested, and structurally violent settings, demands not only methodological rigor but also protocols and planned actions capable of responding to harm, denial, and institutional betrayal. The field has long acknowledged that qualitative methods enable access to lived realities and subjective meaning -making in ways quantitative tools cannot. However, the ethical dimensions of such inquiry often remain structurally underdeveloped, especially when researchers are confronted with ongoing abuse, personal risk, and institutional complicity in the very harms they seek to document (Ellis et al., 2011; Smith & Freyd, 2014; Gabb & Fink, 2015).

This paper arises from such a context. Drawing on longitudinal action-research and participant observation conducted within mental health systems across Europe and Southeast Asia, it seeks to examine the profound ethical and methodological challenges that emerge when institutions tasked with care and protection act as sources of harm. In particular, the analysis is grounded in cases where researchers and participants alike faced coercion, discrediting, and systemic silencing under psychiatric, legal, and social service frameworks that perpetuated -rather than alleviated- distress. In response, new methodological practices were developed under duress, based on the principles of

epistemic justice (Fricker, 2007), open science (Nosek et al., 2015; Munafò et al., 2017), and research ethics grounded in participatory global health (Campbell & Burgess, 2012; WHO, 2021).

The paper does not offer a single-case reflection or a confessional narrative. Rather, it interrogates the ethical failures that occur when systems distort the researcher-participant relationship into an adversarial dynamic, obscuring accountability and harming the production of valid knowledge. The work contributes to an urgent conversation about what happens to ethics, science, and professional duty when research unfolds in spaces of state-sanctioned violence and societal denial. In doing so, it also aims to offer a path forward: a set of methodological countermeasures and epistemic infrastructures that may help restore the integrity of qualitative inquiry.

Ethics and method in qualitative mental health research: innovations and ongoing issues

Over the past two decades, the growth of qualitative approaches in mental health research has been accompanied by a richer vocabulary around reflexivity, power, and the researcher's positionality (Berger, 2015; Pillow, 2003). Despite this, dominant frameworks still tend to favor procedural ethics -such as institutional review board approvals -over emergent, responsive ethics of care and justice in the field (Guillemin & Gillam, 2004; Hammersley & Traianou, 2012). In situations involving vulnerable populations, this disconnect often renders ethical approval a bureaucratic formality rather than a real safeguard. Furthermore, the entrenched hierarchies of biomedical psychiatry -frequently upheld by legal and clinical structures- create environments where participant autonomy is already structurally constrained (Rose, 2018; Hopper, 2007). In such contexts, qualitative researchers face unique ethical challenges, as they navigate not only the dynamics of power and disclosure but also the risk of becoming complicit in systems that criminalize distress and pathologize resistance.

A particularly underexplored area is the ethical terrain encountered when researchers themselves are subjects of the systems they study -not by methodological design, but by circumstance. Researchers who are survivors of institutional violence or coercive treatment, or who work in precarious legal and political conditions, are often left out of the academic conversation or treated as methodologically suspect (Kovach, 2009; Ladkin, 2020). Yet, their work offers rare insight into the inner logics of exclusion and harm. It also reveals how traditional notions of distance, neutrality, and objectivity can obscure the very abuses that demand exposure. The concept of witnessing in qualitative research -long explored in feminist and postcolonial studies- must therefore be reframed not only as interpretive engagement, but as ethical risk (Josselson, 2007; Bhattacharya, 2016).

The erosion of trust in science, exacerbated by epistemic injustice and institutional cover-ups, underscores the need for research practices that prioritize transparency, accountability, and radical honesty (Edwards & Roy, 2017; Ioannidis, 2005). The replication crisis and open science movement have largely bypassed the domain of qualitative mental health research, where practices of data sharing, protocol transparency, and version-controlled documentation remain rare. This gap is especially dangerous given the increasing criminalization of dissent, the medicalization of suffering, and the state-sponsored redefinition of deviance as illness (Foucault, 1973; Metzl, 2010).

At the same time, international health bodies -including the WHO, the UN Special Rapporteur on the right to health, and the Council of Europe- have called for a shift away from coercive psychiatry toward voluntary, rights-based models grounded in human dignity and community engagement (WHO, 2021; Pūras, 2020; Council of Europe, 2023). These mandates demand a corresponding transformation in how qualitative researchers design, conduct, and defend their work -especially in

terms of how we define safety, power, and harm. Without such a shift, researchers risk perpetuating the very systems they critique.

Paper structure and raison d'etre of it as a contribution

This paper proposes a grounded, practice-based ethics framework derived from action-research conducted in real-world mental health systems operating under institutional decay and systemic violence. Through fieldwork conducted in Spain, Sweden, Indonesia, and other European contexts - much of it under conditions of personal duress and danger- the research identifies structural failures in ethical oversight, as well as emergent practices of resistance through documentation, co-production, and digital transparency. It introduces methodological adaptations developed to ensure research could continue in hostile environments, including public verification, trauma-informed consent, and multi-layered data preservation against sabotage or deletion.

The central contribution is twofold. First, it expands the discourse on research ethics in qualitative psychology to include conditions of structural coercion, epistemic harm, and researcher-survivor entanglement. Second, it articulates concrete methodological innovations that uphold integrity, safety, and social accountability even when institutional safeguards fail. In this sense, the paper builds on and extends calls for a paradigm shift in mental health research -from treating ethics as compliance, to enacting ethics as method.

Subsequent sections of the article detail the methodological choices made, the ethical dilemmas encountered, and the principles guiding the design and dissemination of open, survivable, and impactful research. These include the use of participant-led inquiry, open-source infrastructure, co-developed policy engagement, and trauma-aware fieldwork practices. In doing so, the paper argues for a redefinition of ethical research practice not as risk aversion, but as principled exposure in service of truth, healing, and justice.

Background and context: structural deficits, institutional abandonment, and the ethics of listening in qualitative mental health research

Ethical qualitative inquiry in mental health must grapple with the stark dissonance between the professed values of care systems and the lived realities experienced by those navigating them. Across many contemporary psychiatric services in Europe and beyond, the gap between stated therapeutic goals -such as recovery, trauma- informed care, and patient autonomy -and the practical functioning of institutions remains wide and concerning (Rose, 2018; WHO, 2021; UN Human Rights Council, 2023). Despite rhetorical shifts toward personalization, co-production, and rights-based practice, implementation remains sporadic and structurally constrained. The result is a mental health landscape marked not by deliberative reform, but by inertia, bureaucratic rigidity, and the persistent normalization of harm.

This paper emerges from action-research engagements embedded in this terrain. Between 2020 and 2024, fieldwork was conducted across Spain, Sweden, Indonesia, and Italy, focusing on the ethical and methodological challenges of working within -and often despite- systems ill-equipped to engage constructively with distress. The scientific mission in Trieste, Italy, initially pursued as a site of exposure to non-coercive, community-based psychiatry, revealed in parallel the institutional limitations even of globally recognized models. Despite strong international standing, the infrastructures for ethical reflexivity and researcher protection were severely lacking. When the researcher reported ongoing threats and trauma, academic and health institutions failed to respond

meaningfully. This aligns with a growing body of literature suggesting that institutions tasked with mental health and academic oversight frequently lack the mechanisms -or will- to protect those most vulnerable, including researchers and participants disclosing abuse (Gabb & Fink, 2015; Ladkin, 2020; Smith & Freyd, 2014).

These deficits are not uniformly malicious in intent, but are structurally embedded in psychiatric systems where coercion is normalized as care, and deviation from standardized protocols is often met with institutional resistance rather than curiosity or adaptation (Burstow, 2015; Minkowitz, 2006). Mental health legislation in many jurisdictions, including Spain and Sweden, continues to prioritize control over protection, authorizing involuntary treatment without adequate safeguards or meaningful engagement with the person's history, trauma, or social determinants (Gooding, 2015; United Nations, 2017). Even where reform is pursued, the emphasis tends to fall on procedural compliance rather than substantive transformation -a process that risks replicating violence under new administrative terms (Hummelvoll et al., 2015; Russo, 2016).

Clinically, this manifests in practices that are not trauma-informed but frequently retraumatizing; not personalized, but pathologizing; not dialogical, but diagnostically reductionist. Distress signals and embodied protest are often interpreted through narrow, deficit-based frameworks, leading to treatment paths characterized by force, surveillance, and disempowerment (Rose, 2003; Johnstone & Boyle, 2018). Qualitative researchers working in these contexts, particularly through ethnographic or action-based approaches, often witness firsthand how epistemic hubris and institutional closure combine to produce profound iatrogenic effects -including despair, resignation, and what has been termed the *giving up–given up* syndrome (Sharfstein, 1985; Estroff, 1981). The systematic refusal to listen to complaints without retaliatory pathologization or escalation of coercion is not an anomaly but a pattern -one that renders the ethical position of the qualitative researcher particularly precarious, especially when they attempt to surface these dynamics through evidence-based critique.

Importantly, the moral economy of psychiatry continues to reward compliance and silence, while punishing dissent -even when that dissent is expressed through scientifically grounded, patient-informed critique. This context severely limits the capacity for mental health systems to engage in the kinds of self-correction and continuous learning that define a functioning scientific or therapeutic institution. Without open science standards, longitudinal tracking of outcomes, or verifiable feedback loops, the system lacks mechanisms to detect, let alone redress, its own failures (Ioannidis, 2005; Munafò et al., 2017). The resulting epistemological environment not only devalues qualitative insight but actively marginalizes lived experience as methodologically illegitimate and politically destabilizing (Fricker, 2007; Russo & Sweeney, 2016).

This paper argues that qualitative research in such settings is not ethically neutral terrain. When services fail to meet the minimum thresholds of safety, responsiveness, and respect, the act of qualitative inquiry becomes ethically charged -not only for participants but for researchers themselves, especially when their role straddles the boundary of witness, analyst, and survivor. It is in these moments that the ethical demands of the field exceed procedural checklists and enter the domain of moral urgency. Listening, in such contexts, becomes an act of resistance and reparation- a way of refusing the silencing mechanisms that define much of institutional psychiatry and social care (Campbell & Burgess, 2012; Gill & Donaghue, 2016).

Rather than replicating the diagnostic gaze, this study engaged in co-constructed meaning-making, trauma-informed documentation, and action-oriented dissemination. Methodologically, it was anchored in open science principles, collaborative interpretation, and public accountability, seeking to counterbalance the structural opacity that so often defines psychiatric systems. The core contention is that any system incapable of hearing the voices of those it purports to serve -including patients, professionals, and researchers- is ethically unfit. Qualitative research must thus do more than describe -it must interrupt, question, and reconstruct the very conditions under which mental health knowledge is produced and legitimized.

Methods: action-based qualitative research as a platform for systemic learning and structural accountability

This study employed a transdisciplinary, multi-sited qualitative action-research methodology grounded in medical anthropology, biocultural analysis, and epistemic justice frameworks (Fricker, 2007; Scheper-Hughes, 1992; Fals-Borda, 1991). The fieldwork -spanning five years and funded through two consecutive Spanish Ministry of Science and Innovation grants (FPU19/00656 and EVC2021/000764), as well as through participation in European COST Actions FOSTREN (CA19133) and ReMO (CA20137)- was embedded in collective international efforts to rethink mental health governance, research ethics, and service design. It later provided the empirical and ethical foundation for the creation of the EU COST Action BEACON (CA24106), which now brings together over 500 researchers and practitioners committed to systemic transformation through One Health education.

The work took place across Spain, Sweden, Italy, and Indonesia, capturing both formal institutional environments and informal community practices. These sites revealed differing but overlapping patterns of psychiatric violence, coercive logic, epistemic injustice, and institutional betrayal. In all contexts, participants reported harms occurring not only within psychiatric systems, but across intersecting domains -family, police, judiciary, and social services- requiring a broad-based methodological strategy that was responsive to multiple axes of oppression and systemic inertia.

The approach prioritized immersion and ethical responsiveness rather than protocol-driven neutrality. Ethnographic techniques -including long-term participant observation, semi-structured and unstructured interviews, clinical shadowing, policy consultations, and open scientific commentary- were employed to collect data while remaining situated within live processes of witnessing, translation, and reform. The researcher was an active participant in numerous policy and service-level dialogues, including those with the Catalan Department of Health during the co-development of its 2023–2025 Mental Health Action Plan. Engagement included several in-person and written consultations with the plan's leadership and working groups, drawing on lived experience, empirical observation, and participatory policy translation. These dialogues were part of broader EU-wide work under FOSTREN to reduce coercion in mental health systems, and were integrated into BEACON's ongoing mission to foster public education, civic health literacy, and early prevention through participatory infrastructures.

The methodological design was aligned with a tradition of emancipatory and care-centered research (Torre, 2009; Campbell & Cornish, 2010), emphasizing listening, collaborative meaning-making, and systemic reflexivity. However, it also contended with the serious limitations researchers face when working in environments of institutional abuse or neglect. The original field design included

two strategic innovations that remain largely aspirational at this stage due to lack of institutional uptake:

1. Dynamic ethics and action protocols (proposed, not yet implemented): in response to repeated accounts of systemic harm, the research proposed an escalation framework for activating protective responses -including notifying trusted institutional contacts, human rights observers, and professional ethics boards- when credible risks to participant wellbeing emerged. However, the lack of operational infrastructure across public systems, as well as the adversarial posture of many services toward independent researchers, prevented systematic implementation. These protocols are conceptualized as urgently needed components of future public mental health systems.

2. Versioning and verification against epistemic manipulation (proposed, not yet implemented): The project also outlined a need for systematic version control, timestamped medical record retention, and independent archival methods to prevent retrospective data falsification and epistemic erasure - a pattern documented by participants and observed in multiple institutions. While open science principles (Nosek et al., 2015; Munafò et al., 2017) were followed wherever feasible through public reporting, engagement, and collaboration, robust infrastructure for verification and co-governance of sensitive health records remains absent in most countries studied. These proposals are now being translated into design criteria for expert systems and governance pilots under the EU BEACON initiative.

3. In practice, the methodological commitments took shape through the following operational principles, enacted all through the five years of fieldwork:

- Embedded ethnography and policy interface: All fieldwork was informed by direct contact with practitioners, service users, administrators, and policymakers. Findings were translated into contributions to policy documents, public statements, and legal submissions. These include substantive inputs to the Council of Europe's 2023 *Compendium of Good Practices to Promote Voluntary Measures in Mental Health*, and public dissemination through open access formats and digital engagement platforms, and insights directly shared with lawmakers in all opportunities fostered and encountered during the fieldwork research.

- Trauma-informed and participatory consent practices: All participation in surveys and other engagements such as interviews or presentations was always voluntary, and consent was reiterated throughout the process. Participants were informed of the project's dual research and action-reform purposes. In trauma-related cases, no personal identifiers were recorded unless explicitly consented to, and anonymization was prioritized in all outputs.

- Real-time feedback and iterative reflection: Data analysis was recursive, taking place alongside ongoing field engagement. Ethical tensions, institutional challenges, and methodological dilemmas were recorded in analytic memos and served to refine subsequent engagement, published as transparently and in depth as possible in an open field and laboratory notebook online the author keeps, following open science principles of full openness and transparency on methods, ongoing work and results. This reflective praxis was central to maintaining fidelity to the action-research tradition and resisting extractive logics.

- Use of public and community knowledge systems: The research was also attentive to grassroots initiatives, survivor-led campaigns, and international networks working on systemic change. These informants were not merely supplementary but were treated as

epistemic co-producers of the research (Harding, 1991; Saini, 2020), essential to building a distributed model of accountability and system reform.

- Education and dissemination as method: The work's methodological strategy included the development of public teaching materials, professional workshops, and policy briefings aimed at enabling other researchers, clinicians, and students to identify coercive dynamics, respond to systemic failures, and take part in a collective reform agenda. These materials now inform open-access curricula and clinical ethics platforms within the BEACON network.

Despite the comprehensive design, the project was carried out under conditions of acute duress, including repeated threats, lack of institutional protection, and periods of forced displacement due to ongoing violence. That such research was possible at all is testament to the courage of participants, the international scientific alliances that provided support (notably COST Action FOSTREN and later BEACON), and the resilient commitment of affected communities. The qualitative research insights derived are not just valid -they are urgently necessary.

Table 1. Methodological design and operational principles

Component	Description
Theoretical framework	Grounded in medical anthropology, biocultural analysis, and epistemic justice.
Geographic scope and sites	Spain, Sweden, Italy, and Indonesia – encompassing both formal psychiatric institutions and informal community-based systems.
Funding and institutional support	Supported by Spanish Ministry grants (FPU19/00656, EVC2021/000764), and European COST Actions: FOSTREN (CA19133), ReMO (CA20137), and BEACON (CA24106).
Main ethnographic techniques	Long-term participant observation, un/structured interviews, clinical shadowing, policy consultation, and open scientific commentary.
Embedded policy engagement	Participated in development of the Catalan 2023–2025 Mental Health Action Plan; involved in Council of Europe and BEACON policy dialogues.
Research conditions	Fieldwork conducted under duress: threats, institutional neglect, and forced displacements. Research carried forward through participant solidarity, scientific alliances (notably BEACON and FOSTREN), and ethical commitment.
Guiding conclusion	Ethical qualitative research must integrate implementation pathways and inform systemic change; ethics in the field is inseparable from ethics in governance.

To translate lived harms into institutional reform, qualitative research must embed itself in systems of implementation. As this project demonstrates, ethics in the field cannot be divorced from ethics in governance. What we observe must inform what we build next.

Findings and discussion: witnessing without safeguards -ethical tensions and systemic impasses in psychiatric fieldwork

Across five years of multi-sited, ethnographically grounded research in Spain, Sweden, Italy, and Indonesia, this study documented recurring patterns of structural neglect, diagnostic violence, epistemic erasure, and systemic impunity in mental health service ecosystems. The findings cohere around three interrelated domains: the normalization of coercion, the institutional silencing of abuse narratives, and the fragility of ethical responsibility within professional cultures. Each of these

domains poses acute challenges to qualitative researchers, who -once situated in the field- encounter not only suffering but the systemic resistance to its recognition, redress, or repair.

1. Normalization of coercion and the medicalization of structural distress

Participants repeatedly described how psychiatric labeling functioned not as a diagnostic aid but as a mechanism of social disqualification, often weaponized during moments of crisis, family conflict, or institutional breakdown. Particularly in Spain and Italy, users recounted being involuntarily hospitalized or medicated after disclosing experiences of domestic abuse or workplace violence, suggesting that psychiatric systems often reinforce rather than interrupt cycles of harm (Burstow, 2015; Cosgrove et al., 2020). In Sweden, this pattern intensified into what many described as *administrative disappearance*- the use of child protection laws, mental health statutes, or forensic psychiatric classifications to sever individuals from their families, terminate careers, or justify long-term isolation.

These findings resonate with international concerns about the pervasive misuse of psychiatry as a means of social control (Cohen, 1985; Amnesty International, 2022), especially where coercion is framed as care and dissent is medicalized. The normalization of forced treatment was rarely questioned by professionals, many of whom cited *risk* or *non-compliance* in circular terms. This aligns with prior critiques that biomedical mental health paradigms often obscure the social origins of distress while silencing critique through institutional authority (Moncrieff, 2008; Mills, 2014). Where listening did occur, it was more often by peers, advocates, or researchers than by clinicians, indicating a severe epistemic asymmetry within clinical settings.

2. Institutional betrayal and the ethical silencing of field reports

A major theme emerging from the fieldwork was the impossibility of *reporting upward* in situations of witnessed harm. Whether abuse occurred in hospitals, homes, or welfare offices, researchers and witnesses alike found themselves without secure channels to raise alarms. Reporting often triggered retaliation, deflection, or reputational damage-especially when clinicians, administrators, or legal authorities were implicated. In multiple cases, researchers were warned against *interfering* or *taking sides*, even as participants suffered ongoing harm.

For instance, the researcher's report of suffering a death threat, torture for years and still ongoing severe abuses, was met not with institutional support but with inaction that lead to even further threats, harassment, violence, forced displacement, and denial of professional legitimacy, illustrating the punitive asymmetry between those speaking out the truth, denouncing crimes, and those structurally shielded. This mirrors the dynamics described by Smith and Freyd (2014) as institutional betrayal, in which organizations fail to respond ethically to harm within their own systems, compounding trauma and silencing accountability.

The field thus became a space not only of witnessing but of betrayal. Ethical tensions were acute: to disengage would be complicit; to intervene risked professional collapse. In the absence of dynamic protocols or institutional accountability, the ethical burden fell entirely on the individual researcher, exacerbating precarity and psychological toll.

3. Complicity, cowardice, and the reproduction of structural harm

A sobering finding was the extent to which professional cultures, especially among clinicians and researchers, normalized avoidance, deflection, and passive complicity. Even where clear violations

were witnessed, many professionals invoked bureaucratic constraints, *non-interventionist* roles, or institutional neutrality as reasons for inaction. This passive complicity constitutes a core mechanism of harm reproduction. Worse still, some actors actively participated in the erasure or defamation of those who challenged the status quo, often under the guise of procedural correctness or reputational protection. This condition, what Freire (1970) would call the internalization of oppressor logic, undermines the very fabric of ethical inquiry. It also challenges the assumptions of procedural ethics, which presume a stable environment of rights, protections, and institutional cooperation. In reality, the field often operates as a site of moral injury, where truth-telling becomes a liability and protection is only extended to those who remain silent.

These findings compel a reframing of ethical practice in qualitative research. If researchers are to carry the burden of witnessing systemic abuse, then institutions -academic, clinical, legal- must be made accountable for offering protection, coordination, and escalation pathways. The ethics of doing no harm must evolve into an ethics of enabling redress and reform.

4. Action-research under duress: method as resistance

That this research was conducted at all -despite displacement, threats, and lack of institutional protection- testifies to the necessity of integrating ethics into method. In contexts where silence sustains violence, the very act of documentation becomes resistance. The work was undertaken with clear goals: to expose systemic failures, to amplify silenced voices, and to push for reform from within the systems themselves.

Table 2: Ethical issues in mental health qualitative research

Field	Description
Positional risk and exposure	Researchers with lived experience or dissenting perspectives face systemic retaliation, delegitimation, and psychological harm when documenting abuse.
Structural silencing and retaliation	Institutional actors obstruct reporting pathways, retaliate against whistleblowers, and pathologize critics as unprofessional or mentally unfit.
Informed consent and coercive environments	Consent is undermined in coercive contexts, where patients fear retribution, service loss, or further diagnosis for speaking out.
Power asymmetries in field relations	Researcher-participant relationships reflect deep institutional power imbalances, risking complicity without reflexive, relational ethics.
Epistemic violence and testimonial erasure	Participant testimony is often dismissed or erased in clinical and professional settings, reinforcing structural invisibility.
Barriers to real-time ethical action	Ethics protocols lack mechanisms for immediate response to abuse disclosures, leaving researchers without safe and effective intervention channels.
Data integrity and record manipulation	Mental health records are vulnerable to falsification or selective editing, requiring researchers to ensure timestamped, version-controlled documentation.
Public health system complicity	Harm and neglect are normalized within systems of care, placing researchers in ethical dilemmas where harm is concealed or trivialized.
Lack of institutional protection	Universities and research bodies often lack protocols to protect researchers from fieldwork-related risks or from institutional retaliation.
Ethics of translation and policy feedback	Testimonies often fail to reach decision-makers; researchers must forge independent pathways to transform lived knowledge into systemic change.

Major critical ethical concerns encountered and analyzed in the course of longitudinal action-research in mental health services and institutional systems.

Yet, the findings also underscore a profound need for collective infrastructure. No individual researcher, no matter how dedicated, can bear the epistemic, emotional, and political weight of reform alone. Qualitative research, especially in mental health, must now advance into a new era of institutional ethics -in-action, where protocols, accountability mechanisms, and open-science safeguards support the very interventions they demand (Guillemin & Gillam, 2004; Iphofen, 2017).

This five years long fieldwork research was not about individual suffering, though it was shaped by it. It is about systemic ethical blindness -and the urgent task of building a scholarly and clinical culture that not only sees, but acts. Qualitative research in mental health, particularly when employing ethnographic and action-research methodologies, reveals a persistent and structurally embedded set of ethical dilemmas that cannot be addressed solely by procedural ethics or institutional review boards. Across multiple sites and over a sustained five-year field engagement-including participation in EU-funded initiatives such as FOSTREN, ReMO, and the EU BEACON actions- the findings consistently exposed environments where lived experience is delegitimized, institutional violence is normalized, and the epistemic authority of survivors, patients, and front-line researchers is regularly undermined or pathologized. These findings echo prior critiques of ethics-as-bureaucracy and support the call for dynamic, responsive, and relational ethical frameworks (Guillemin & Gillam, 2004; Denzin & Giardina, 2007; Ellis, 2007).

A key ethical concern centers on the erasure of lived experience under epistemic regimes of biomedical dominance, where subjective accounts of harm, coercion, and structural neglect are recast as symptomatic of illness rather than legitimate evidence. This epistemic injustice (Fricker, 2007) is compounded in contexts where diagnostic power is weaponized to silence critique,

rendering the very act of naming abuse a trigger for further institutional punishment or control. Participants in multiple sites reported that attempts to speak out about coercive practices -including forced medication, restraint, and isolation- were reinterpreted as signs of *lack of insight* or *paranoia*, thus perpetuating cycles of disempowerment and silencing (Russo, 2016; Voronka, 2016; Rose & Kalathil, 2019). These dynamics raise fundamental questions about the ethics of consent, voice, and narrative agency within qualitative inquiry.

Moreover, the asymmetry of power between researcher and participant -typically acknowledged as a risk- was reversed in many cases, as researchers embedded in vulnerable positions themselves became targets of institutional repression. When qualitative researchers are also survivors, or operate as peer scholars in precarious environments, the ethical equation shifts drastically. In this research, the act of documentation itself often triggered surveillance, retaliation, or professional sanction. Despite formal ethics approval and institutional affiliations, safety was not guaranteed. Research supervisors, in some cases, failed to respond adequately to threats, abuse, or violations reported during fieldwork -effectively enabling a culture of institutional abandonment. The absence of protective mechanisms for researchers themselves, particularly those working at the intersection of care and critique, reflects a profound ethical gap in current academic infrastructures (Berger, 2015; Gill & Orgad, 2018).

A second major ethical issue relates to the lack of pathways for institutional responsiveness to qualitative findings. Participants shared urgent testimonies of maltreatment, neglect, and even criminal acts within care systems. Yet, qualitative research in mental health lacks clear ethical protocols for real-time response and coordinated redress. The research identified repeated failures by health and social care services to act upon evidence presented informally or formally. This undermines not only the principle of beneficence but also the scientific and civic legitimacy of the research itself. Unlike biomedical trials, which often have established pathways for reporting adverse events, qualitative research in mental health lacks protocols for activating ethical alerts, documenting high-risk environments, or reporting practitioners engaged in harmful behavior (WHO, 2021; Campbell & Burgess, 2012).

The relational ethics of field engagement were further complicated by the presence of institutional actors who blurred the boundaries between care provider, researcher, gatekeeper, and enforcer. These overlapping roles made it difficult for participants to trust the research process, fearing retaliation, breaches of confidentiality, or collusion with coercive systems. Even when anonymity was assured, the localized nature of mental health services made it difficult to protect identities in small, tightly networked communities. This created a chilling effect, where many potential informants withheld key information, fearing that their cooperation could worsen their situation. Similar challenges have been documented in mental health ethnographies and survivor-led research, where the relational risks of speaking out are high and institutional cultures are resistant to scrutiny (Chamberlain, 2000; LeFrançois, Menzies & Reaume, 2013).

A further finding concerns the moral burden placed on researchers conducting fieldwork in contexts of unresolved trauma. Many participants were actively experiencing distress, institutional betrayal, and unresolved grievances. In such contexts, the researcher cannot ethically remain a neutral observer. The findings call into question the adequacy of traditional models of ethical distance and non-intervention, and instead support the development of trauma-informed, action-oriented, and co-produced research ethics frameworks (Sweeney et al., 2018; Beresford, 2016). This includes

protocols for emotional labor, peer debriefing, mental health support for researchers, and ethical exit strategies that avoid retraumatization or abandonment of participants post-fieldwork.

Finally, the limitations of formal ethical oversight bodies were starkly apparent. Ethics committees rarely have expertise in action-research or survivor-led inquiry, and often default to rigid procedural concerns that fail to account for emergent, situated ethical dilemmas. In this research, the need for real-time response mechanisms, version-controlled documentation, secure archiving of sensitive data, and collaborative decision-making far outstripped the static guidelines provided by institutional review boards. These findings echo broader calls for ethical governance reform in research with structurally vulnerable populations (Flicker et al., 2007; Mertens, 2009; Fistein & Quilligan, 2012).

Thus, to be effective and prevent further harm, violence and normalized crimes from repeating, qualitative research in mental health, especially when it engages directly with sites of coercion, exclusion, and structural abuse, must be governed by ethics that are dynamic, grounded, and protective-not merely procedural. The findings of this research contribute to an emerging body of literature demanding that we rethink ethics not as an administrative hurdle but as a living, collective practice of care, justice, and accountability, including protocols of action in case of witnessing or finding out about potential crimes, or severe cases of suffering and violence not yet recognized by practitioners and other colleagues. This shift is not optional -it is the only path forward in a field where human lives, rights, and futures are continually at stake.

Conclusion

The ethical complexities unveiled through this five-year action-research project challenge the very boundaries of what constitutes safe, just, and scientifically grounded qualitative research in mental health. Rather than isolated dilemmas, the findings portray a systemic failure to uphold ethical responsibilities across institutions, services, and research infrastructures. Participants' testimonies of harm -routinely pathologized or erased- reflect not only epistemic injustice (Fricker, 2007; Kidd & Carel, 2017), but an entrenched structural tendency to deny, suppress, and retaliate against uncomfortable truths. Researchers committed to action-oriented methodologies become both witnesses and targets of this violence, confronting a research environment hostile to reflexivity, transparency, or critical accountability (Guillemin & Gillam, 2004; Denzin & Giardina, 2007).

These issues are magnified in contexts like Spain, Sweden, and Italy, where mental health policy and law remain disproportionately focused on control and containment rather than care and redress (Dvoskin & Skeem, 2009; Rose, 2014; Foucault, 2003). Despite recent progress and international declarations urging non-coercive, rights-based approaches (WHO, 2021; Council of Europe, 2023), the operational mechanisms needed to integrate real-time testimony into systemic reform are largely absent. Ethical review boards lack dynamic, context-sensitive protocols. Public institutions often default to denial rather than support when presented with evidence of abuse or malpractice. And researchers, particularly those with lived experience or outsider positionality, are rendered expendable when the truths they uncover threaten institutional interests (Gill & Donaghue, 2016; Clegg, 2016). What this research demonstrates is not simply the presence of ethical risk, but the urgency of a structural reconfiguration. Participatory ethics cannot be procedural; it must be infrastructural. Dynamic feedback loops, public data protocols, and built-in escalation pathways for rights violations must be adopted as core features of qualitative inquiry in mental health. Moreover,

universities and public research funders must abandon extractive models of knowledge production in favor of protective, collaborative, and system-improving commitments.

At its most vital, qualitative research is not merely a tool for documentation -it is an instrument of justice, of collective repair, and of epistemic reckoning. This research, embedded in several relevant EU COST actions, such as FOSTREN, culminating in the creation of the EU BEACON One Health Education one, demonstrate the potential of international cooperation to create research ecosystems where testimony is met with transformation, and where those who suffer are no longer expected to remain silent. Our future, at the scientific, social, and planetary levels, depends on our job properly done, following the highest ethical and open science standards, coordinately with other professionals also enforcing the highest possible best practices together.

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