ST. STEPHEN'S COLLEGE

NURSES' EXPERIENCE OF WORKPLACE VIOLENCE BEFORE AND AFTER A FOCUSING WORKSHOP

by

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Dedicated To:

A living breathing talking walking human angel

With huge white wings and a very golden halo

Dr. Leslie Gardner

Abstract

This hermeneutic study of workplace violence demonstrated that trauma, as a result of intercollegial violence, can be processed. *Focusing* can be applied as an intervention for intercollegial violence in nursing practice environments, which opens up possibilities of engagement with the universal condition of suffering. Suffering, within the context of the thesis project, exists when a nurse experiences trauma and incurs a wound, consciously or unconsciously dealt or received, through an abusive interaction with a colleague. *Focusing* may be explained as a self-exploration and self-reflection based on listening to the body's wisdom (Gendlin, 2007; Madison, 2001). The key discovery in *Focusing*'s evidence-based research is that a person's ability to affect change depends on how closely he/she attends to his/her experiencing.

For the purpose of this study, five themes were identified and explored: workplace violence, poor healthcare (its effect on an individual's stress level), resilience (an individual's ability to rebound), embodied spirituality (in relation to an individual's sense of health and wholeness), and embodied caring (the human's connection to the complex life force of environment, Self/body). Because of metaphor's usefulness in qualitative research (closer to "story" than statistics), metaphoric elements were explored during the Pre-and Post-*Focusing* workshop interview stages of the study. Implications for the co-researchers, the practice of the researcher, the healthcare system, the *Focusing*, counselling, and psychology communities were identified.

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It is difficult to even admit that we could be hurting each other in a profession that has its fundamental roots in caring. Uncovering and discussing horizontal hostility is about as easy as a family acknowledging how damaging it is to live with alcoholism. It is embarrassing and is so remotely removed from our idea of the perfect nurse that we shudder to think that it may be true. In addition, there is an unspoken fear, warranted or not, that acknowledging the problem will make it worse. However, if nursing is to survive, we need an immediate intervention. This intervention starts with listening to the voices in the room--the researchers who have uncovered this behaviour, and the nurses who are experiencing the hostility.

Kathleen Bartholomew, RN, MN (2006)

Chapter One: Introduction

The significance, i.e. relevance and purpose of this research project, was to explore *Focusing* as a possible intervention for use by nurses who have experienced intercollegial workplace violence. This introduction will: a) discuss the various shaming behaviours which are interpreted as intercollegial violence in nursing practice settings; b) provide a description of the intervention *Focusing*; c) show how *Focusing* can assist with alleviating suffering; d) discuss *Focusing* and the bodily felt sense of a situation; e) present a description of the larger authentic Self; and f) describe the nature of intercollegial violence.

Chapter Two presents a literature review of workplace violence in the healthcare sector. This literature speaks, at a national and international level, about the concerns and complexity of workplace violence in the healthcare sector. Prevention and interventions for workplace violence will be discussed at both an individual and organizational level. *Focusing* as an intervention is suggested as a complement to the litany of researched interventions.

Chapter Three describes the methodology of hermeneutic/interpretive Phenomenology Research Design, including how co-researchers were selected, and how data was collected, analyzed and interpreted. Chapter Four describes the ethical behaviour of the researcher when conducting this research, including the issue of trustworthiness and the limitations of the research project. Chapter Five provides storyettes from the five co-researchers, which give an overall sense to the reader of the co-researchers' workplace violence experiences**.** Chapter Six is a summary of findings and discussions from the five Pre- and Post-*Focusing* metaphor interviews and Chapter

Seven presents the five Pre- and Post-*Focusing* interview themes with the corresponding sub-themes, findings and discussion.

Chapter Eight discusses the implications developed from the results, including: a) implications for the co-researchers; b) implications for me, the researcher; c) implications for the healthcare organizations; and d) implications for the *Focusing* community. How the results apply to counselling and psychology are also discussed along with the implications for the research project itself. Finally, Chapter Nine provides a summary and a general conclusion.

Purpose of this Project

Nurses readily take on leadership roles to ensure quality workplace environments but they also tend to avoid conflict and choose not to intervene when conflict does surface (Canadian Nurses Association (CNA), 2010). Further, nurses sometimes use shaming behaviours such as mobbing, bullying, and marginalizing to deal with conflict and/or to get their needs met (Brown, 2007; Gossen & Anderson, 1995; Rosenberg, 2006). All of these behaviours are known as horizontal/lateral/intercollegial violence (di Martino, 2003; Minnesota Nurses Association (MNA), 1999; Registered Nurses Association of Ontario (RNAO), 2007, 2009; Saskatchewan Registered Nurses Association (SRNA), 2009). It is possible that nurses who are taught *Focusing* (Gendlin, 2007) could raise awareness about such violence-driven behaviours and assist in preventing and/or processing the consequences of such behaviour.

The purpose of this research project was to study the impact of *Focusing* on the experience of nurses burdened by workplace violence and to explore the feasibility of using *Focusing* as a possible future intervention. This project identified themes,

characteristics, attitudes, behaviours, actions, skills, and “ah-ha” moments that nurses experienced before and following the preparation and practice in *Focusing*. Studying *Focusing* as a possible intervention for nurses burdened with workplace violence may add to the literature on how to enhance quality nursing workplaces.

Research question.

Does the preparation and practice of *Focusing* impact the nurses’ experience of workplace violence?

Personal and professional interest.

I have been involved in many nursing workplace environments as a bedside nurse and as a nursing educator. As well, I am currently employed in a nursing education environment in a prairie province college. Past research suggests that nursing education work environments produce the most communication challenges within the nursing profession (Clark & Springer, 2007). As well, the RNAO (2009) states that nursing needs to

> recognize that intended and unintended forms of incivility, aggression and violence enacted in academic and clinical settings can serve to reproduce and escalate violent behaviours and practices between and among all healthcare professionals in academic and healthcare organizations. (p. 8)

I have certainly experienced, witnessed and intervened with these communication challenges frequently within many nursing workplace environments, both as a nurse educator and as a nurse. I have found intercollegial workplace violence in the nursing practice settings to be a tremendous burden, both in and out of work time.

The SRNA's NewsBulletin (Riehl, 2009) featured an article, *Commitment to Co-Workers Ending Lateral Violence in the Workplace.* This article discussed ten common shaming behaviours under the umbrella of lateral/horizontal/intercollegial violence, including: the breaking of confidences; infighting; scape-goating; lack of respect for privacy; non-verbal posturing; withholding information; verbal affronts; backstabbing; undermining activities; and sabotaging other colleagues (Bartholomew, 2006; Brown, 2007). Clearly such behaviours do occur within nursing workplace environments.

As the SRNA Workplace Representative within the Nursing Education Program of Saskatchewan (NEPS), I was asked to co-facilitate workshops on the new CNA Code of Ethics (2008). A colleague and I facilitated two workshops for the nursing division at the Saskatchewan Institute for Science and Technology (SIAST) to identify relevant ethical situations in the workplace and find ways of enhancing the quality of that environment (McDonald & Hubbard, 2008). Out of these two workshops came a strong group request for a social dialogue within the faculty regarding our own code of conduct and to what extent our values rely on the CNA Code of Ethics guidelines.

I also participated, together with many other healthcare professionals primarily from management positions, in an education certification program at the University of Regina (Martin et al., 2008). During this program there were many sub-teams organized for the purpose of enhancing the health of healthcare workplaces. Our team developed a toolkit and a visual model called the *Workplace Conflict Awareness Model* to promote the understanding among other healthcare professionals that conflict will emerge when working with others and to suggest two possible distinct outcomes (a positive and negative outcome) for conflict in the workplace (Martin et al., 2008). Positive outcomes

flow from embracing conflict as an opportunity to gain skills and enhance workplace relationships. A negative outcome would flow from ignoring workplace conflict as this would send the conflict underground, where eventually it can escalate into destructive behaviours.

In my nursing career so far, I have engaged in nursing interventions with the intent of assisting in preventing and/or resolving horizontal/lateral/intercollegial violence in nursing work place environments. It is my desire to explore how *Focusing* may be used as an intervention for nurses burdened with workplace violence.

As an embodied spiritual being, I have drawn from three sources that discuss how spiritual practices and processes assist the suffering individual (such as the co-researchers in this research project) to engage in a transformational and transcendent growth process seeking spiritual freedom (Hinterkopf, 1998; Scott Barrs, 2010, 2011; Todres, 2007). Hinterkopf describes a spiritual experience as "...a subtle bodily feeling with vague meanings, that brings new, clearer meanings involving a transcendent growth process" (1998, p. 11). This description is in alignment with the experience consistently found in a *Focusing* experience (as described below). Scott Barss (2011) suggests that universal spiritual needs include existential matters such as meaning, reconciliation, trust, hope, purpose, interconnection, creativity and inspiration, all of which enhance spiritual freedom. Scott Barss (2010) also suggested that not providing spiritual care neglects the safety of the person seeking healthcare/therapy. Todres (2007) described spirituality and spiritual experiences as "Embodying Freedom and Vulnerability" (p. 125). One way to elucidate this is not to describe the authentic Self in psychological ways (i.e. as specialized self-perception or as a self-identity or as a being developed from interpersonal

interactions) but rather to say in ontological Heideggerian language that the Self is a "...non-specialized perceptual openness to the world" (Todres, 2007, p.131). This non-specialized openness of human beingness is explained metaphorically as "...'openness', 'lightning' and the 'there'...human existence has its essence in its transcendence..." (Todres, 2007, p. 131).

What is *Focusing*?

As a researcher, I am interested in understanding how the nurse's concerns, skills, habits, actions and shared stories are affected by intercollegial violence and how such experiences may change after the nurses learn *Focusing* skills. Within the context of this research project, *Focusing* is studied as a potential intervention for nurses who have faced intercollegial/horizontal/lateral violence in their workplace environments (Dreyfus, 1994). *Focusing* is a self-exploration and self-reflection process based on listening to the body's wisdom (Gendlin, 2007; Madison, 2001). Past *Focusing* evidence-based research (Wagner, 2006) discovered that the client's ability to affect change depended on how closely he/she attended to his/her experiences (this would be considered a self-reflection process). More explicitly, clients who are able to stay with a physically felt sense of a problem until it gradually becomes fully comprehensible, find that their experience and their life situations change as a result. They find a shift in the experiencing of the problem and a moving forward in their lives. There is openness and clarity rather than a 'stuckness' or a 'closed in-ness' (Campbell & McMahon, 1997; Gendlin, 1986, 1996, 2007; Hinterkopf, 1998).

Gendlin, the founder of *Focusing*, is a contemporary existential philosopher (Cogswell, 2008), phenomenologist and psychotherapist (Gendlin, 1962, 1986, 1996,

2007). *Focusing*, as a phenomenological intervention, can be integrated into other psychotherapeutic approaches. As well, *Focusing* can be learned by an individual and used to resolve everyday problems and challenges so as to move forward towards goals, commitments, purposes and spiritual development (Gendlin, 2007; Hinterkopf, 1998). *Focusing* addresses the immediate subjective experience of the individual and subtly shifts the emphasis from these subjective experiences (thoughts, feelings and behaviours) to focusing on the body's innate experience of life situations (Gendlin, 1962, 1996, 2007). Thus, *Focusing* includes paying attention to the body's sensations, signals, felt bodily discomforts or senses, and images, as well as to thoughts, feelings, and behaviours.

Focusing and Suffering

According to Tinsley and France (2004), nurses leave their profession because of the suffering they experience from nurse abuse and burnout, and subsequently seek to return to something they once loved – nursing. Suffering, as one of the universal human conditions, occurs when the individual perceives an impending destruction of their personhood. Tinsley and France's hermeneutic phenomenological study (2004) suggested that all healthcare workers need to create a "culture of caring" (p. 11) to alleviate suffering and maintain nurses in the workplace. This study relayed the words used by nurses to describe suffering: destroy, hate, angry and rejected. Cassell (1999) suggested that suffering is a threat to the individual's sense of integrity of their personhood and this threat is assessed or self-interpreted by the individual. Suffering is related to physical, psychological, social, emotional and spiritual distress. Cassell stresses the need to recognize suffering so that the person can gain meaning from the lived experience and

engage in a healing process. *Focusing* is one way to recognize suffering and support the individual in a healing process (Gendlin, 1996, 2007; Hinterkopf, 1998).

Egnew's qualitative inquiry (2005) suggested that, through suffering such as illness, the individual has the opportunity to become whole again. The individual has the chance to develop a different relationship with his/her body, with significant others and to the individual's culture.

Hinterkopf (1998) suggests that *Focusing* can help individuals with deep-rooted issues and bring them into a spiritual experience which in turn will strengthen their capacity to engage in stressful situations such as nurse abuse. Hinterkopf speaks to a spiritual/*Focusing* wellness approach that can work with all clients. This *Focusing* approach can work with all cultures, religious beliefs and suffering (deep rooted issues). She states that, "...*Focusing* involves paying attention to whatever is presently felt in the body..." (Hinterkopf, 1998, p. 2), and thereby getting to the root of suffering. Once the individual learns how to pay attention to what the body is experiencing there is the opportunity for transformation and transcendence. The current research project being presented here examined whether *Focusing* can help nurses struggling and/or suffering with workplace horizontal/lateral/intercollegial violence gain inner direction and mediate self-transcendence in order to develop strategies to deal with these types of workplace challenges (Campbell & McMahon, 1997; Hinterkopf, 1998). Further, Cassar and Shinebourne (2012) suggest that spirituality is a powerful internal experience and

> …is only your world inside you, and you discover yourself, discover your experience, your accumulated knowledge from your past lives, and you develop

> yourself for the future and for your next step in this present life, through connection through spiritual moments. (p. 136)

Focusing and the Felt Sense

Focusing is a way of being with oneself unconditionally with curiosity and compassion, which promotes deep self-reflection, deep listening and self-discovery (Madison, 2001). Felt sensing (central to *Focusing*) is one's ability to stay with the concrete felt bodily experience. This is considered a natural way of self-reflecting, thereby gaining awareness/knowledge/wisdom of one's life, developmental and/or spiritual situations. The bodily felt sense is a temporary yet on-going process that is concretely felt in the body, influenced by the individual's moment in time and history. The felt sense or concrete bodily experience is usually (though not always) felt in the "throat, chest, stomach, abdomen" (Madison, 2001, p.1). During felt sensing, the person is thinking and speaking, while being with his/her bodily experience. *Focusing* is being with what is, rather than changing the felt sense experience or doing something to the felt sense and its meaning. Individuals who can stay with a physically felt, yet unclear, sense of a problem until it gradually becomes clearer to the point they are able to express the feeling in some manner using symbolic language, find that their experiences and their problems change as a result.

The larger authentic self.

My description and understanding of the Self comes from many sources. Schwartz (1995) describes the Self as a compassionate, active, inner leader, capable of an expansive state of mind. The Self includes one's ability and capacity to address challenges in the world (McGavin & Weiser Cornell, 2011), as they impact one's

developmental and spiritual life tasks. The Self is experienced as clear, confident, empowering, grounded and centered, but is also experienced as seeing the larger picture of a situation.

The bio-spirituality *Focusing* community suggests there is a connector between humans and the larger body (larger power/God/ Divine/Transcendent), which could be recognized as the Self (Campbell & McMahon, 1997; McMahon, 1993). Hinterkopf (1998) talks about the observer-Self helping the individual establish a safe distance between the self and the overwhelming problem situation without losing contact with the concrete bodily discomfort. The larger authentic Self can bring a 'caring-feeling-presence' to the individual's suffering (McMahon, 1993). In the intervention *Focusing*, the Self can be an inner companion 'with oneself' through thick or thin. The Self can hold the individual's tensions, rawness of feelings, conflicts, suffering and challenges until they transform, heal or transcend. The Self is capable of leading the individual into Self-mastery during times of life's challenges (Madison, 2008). The existential Self struggles to be authentic and has the courage to engage in an ongoing process of becoming (Parse, 1999). The Self is what Heidegger calls "Being-in-the-World" (McGinley, 2011, p. 3). The larger authentic Self holds a creative state and facilitates spiritual practices and processes, which sustain the individual during times of struggling and suffering (Wolin & Wolin, 1993).

The Self, like God, has many names. The Self, also like God/Divine/ Transcendent/larger body/larger power, has the capacity to: a) attend to and listen deeply and widely to the individual's life challenges; b) keep the individual safe; c) hold all challenges unconditionally until they have transcended; d) be an inner companion; e) be

creative; f) be spiritual and expansive in nature; g) be empowering, grounded and centred and h) be a compassionate, wise, inner listener and leader. These descriptions of the Self resonate with the description of spiritual experiences and needs by Scott Barrs (2010, 2011), Hinterkopf (1998), and Todres (2007).

What is Horizontal/Lateral (Intercollegial) Violence?

The experience of horizontal/lateral/intercollegial violence can be defined as "sustained exposure to violence in the workplace, including aggression, abuse and bullying" occurring from worker to worker (RNAO, 2009, p. 20). These shaming behaviours, whether intentional or unintentional, can cause serious physical, social, emotional, mental and spiritual harm to individuals and to the entire environment (Brown, 2007). For this research project, worker to worker means any healthcare worker who works in the same workplace environment such as other Nurses, Physicians, Continuing Care Aides, Licensed Practical Nurses, Occupational Therapists, Recreational Therapists, Physical Therapists, Nurse Educators, Managers interacting with Nurses or any other healthcare providers that interact with the nurse to support the client, resident, or patient.

Horizontal/lateral/intercollegial violence, as with any other workplace violence, "involves misuse of power and control" (RNAO, 2009, p. 30) and is supported by behaviours that are in response to the violent perpetrator's needs for autonomy (power), celebration, integrity (safety), interdependence (freedom), play (fun), spiritual communion, physical nurturance, and rest (Gossen & Anderson, 1995; Rosenberg, 2006). For this research project, lateral/horizontal/intercollegial violence will be written as intercollegial violence.

Chapter Two: Literature Review

Review of the literature includes: a) concerns in the healthcare sector regarding workplace violence; b) prevention and interventions with workplace violence; and c) *Focusing* as a possible intervention for workplace violence.

Concerns in the Healthcare Sector

On a national and international level the RNAO developed a document, *Healthy Work Environments Best Practice Guidelines: Preventing and Managing violence in the Workplace* (RNAO, 2009), which provides 268 references related to workplace violence in the healthcare sector. As the document states, "Creating healthy work environments is both an individual and collective responsibility. Successful uptake of these guidelines requires concerted effort by governments, administrators, clinical staff and others, partnering together to create evidence-based practice cultures" (RNAO, 2009, p. 1). There are several recommendations for the prevention and management of violence in nursing work environments including: a) governments and healthcare organizations which take an active role in building a workplace free of violence; b) researchers who work with governments, regulatory bodies, professional associations, the healthcare sector, educational institutions and unions to gain understanding of workplace violence; c) standards of accreditation that support a workplace-violence-free environment; d) extensive education for all healthcare workers on workplace violence and how to protect themselves; and e) academic settings and regulatory bodies actively set role modelling standards for a violence-free work environment.

The RNAO (2009) document defined four types of perpetrators of violence in the healthcare workplaces but Type III (Worker to Worker) specifically applies to this

research project. A Type III "perpetrator is a staff member or past staff member of the workplace, including managers, workers, physicians, contracted staff or service workers and volunteers" (RNAO, 2009, p. 30) involved in intercollegial violence.

The RNAO (2009) reported that healthcare agencies have difficulty in keeping nurses due to the fact that nurses do not feel supported by management or their co-workers in their practice, nor feel prepared to "cope with aggression from fellow professionals such as peers, faculty and preceptors" (2009, p. 32). The RNAO further reported that bullying (a shaming behaviour) is as embedded in the nursing profession as it is in the larger culture (Brown, 2007). Managerial cultures have tended to ignore and dismiss the concept of a bullying/shaming culture.

The CNA Code of Ethics talks about quality workplace environments: "Such practice environments have the organizational structures and resources necessary to ensure safety, support and respect for all persons in the work setting" (CNA, 2008, p. 5). The CNA Code of Ethics provides guidelines for a nurse's behaviour moment to moment while working in healthcare environments, and these guidelines can be seen as a model for a culture free of workplace violence.

Another important document addressing workplace violence in nursing environments is the *Joint Position Statement: Practice Environments: Maximizing Client, Nurse and System Outcomes* (CNA & Canadian Federation of Nurses Unions (CFNU), 2006). The CNA and CFNU believe that if nursing environments promote safe, respectful, supportive cultures for nurses, positive patient outcomes will be maximized. This document advocates valuing the well-being of employees and clients by the

application of clear workplace guidelines that are assessed continually. Such assessments would lead to the ongoing formulation of strategies to contribute to positive change.

The FactSheet: *Violence in the Workplace* (CNA, 2010) provides general information about violence in the nursing clinical setting and outlines the different types of violence that burden nurses. The main information points of this FactSheet were: a) nurses frequently experience violence in the workplace; b) horizontal/lateral violence is manifested as aggression from one nurse to another nurse; and c) physical, verbal and nonverbal violence are common. Such violence includes disrespect, non-constructive criticism, scape-goating, intimidating, threats, gossiping, nit-picking, silent treatment, gesturing and denial of basic human needs (CNA, 2010). According to the FactSheet, "As many as 72 percent of nurses do not feel safe from assault at work" (International Council of Nurses (ICN); found in CNA, 2010, p. 2). The FactSheet goes on to make a strong statement for healthcare workplace environments suggesting "...zero tolerance of any act of violence..." (CNA, 2010, p. 2).

On the World Health Organization's (WHO) web site under the Joint Programme on Workplace Violence in the Health Sector (WHO, 2010), there are several documents addressing workplace violence including: information leaflets, case studies, research instruments and working papers. All together these form a framework of guidelines addressing health sector workplace violence. In particular, the working paper *Workplace violence in the health sector: Relationship between work stress and workplace violence in the health sector* (di Martino, 2003) speaks directly to workplace violence. This working paper addresses the relationship between stress and violence with doctors, social workers, and nurses, and reports that healthcare sector workplace violence makes up to 25% of all

violence in the workplace globally. As well, di Martino (2003) suggests that both workers and employers are very interested in preventing severe stress and violence in the workplace.

The International Labour Office (ILO), WHO, ICN and the Public Services International (PSI) worked together to launch a joint program for developing policies and practical interventions, “for the prevention and elimination of violence in the health sector” in many countries (di Martino, 2003, p. iii). Further, di Martino (2003) states that, “Stress and violence cause immediate and often long-term disruption to interpersonal relationships, the organization of work and the overall working environment” (p. vii). The study by di Martino (2003) suggested that participating in a social dialogue (such as the Socratic dialogue) helps to diffuse workplace stress and workplace violence. Social dialogue for diffusing work-related violence and stress commits all parties involved to an active participation in ongoing anti-violence and anti-stress initiatives. Employee experience and knowledge, as well as their ways of knowing, needs to be tapped to enhance the workplace environment. This participatory process supports an active role for the healthcare workers, who design and implement interventions.

An important point noted in di Martino’s (2003) document is that, in this program, there is a shift in emphasis from blaming the individual worker (it’s his/her problem) to suggesting that the workplace itself either creates violence and stress or reduces it. I have noted that workplace violence is experienced by all levels of the healthcare sector but I want to state that this research project will focus on the individual level.

Stress and violence (which often overlap) are defined by di Martino as:

> Stress – The physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources or needs of the employee.
>
> Violence – Incidences where employees are abused, threatened, assaulted or subjected to other offensive behaviour in circumstances related to their work. (2003, p. 1)

Specific violent behaviours are defined by di Martino as:

a) Assault/attack–Attempt at physical injury or attack on a person leading to actual physical harm. It includes beating, kicking, slapping, stabbing, shooting, biting, sexual assault and rape, among others.

b) Threat – Menace of hurt or injury resulting in fear of physical, sexual, psychological harm or other negative consequences to the victim(s).

c) Abuse – Behaviour that departs from reasonable conduct and involves the misuse of physical and psychological strength. It includes harassment, bullying and mobbing.

d) Harassment – Unwanted conduct (i.e. verbal, non-verbal, visual, psychological or physical) based on age, disability, status, domestic circumstances, sex, sexual orientation, race, colour, language, religion, political affiliation, trade union membership or other held opinion or belief, national or social origin, association with a minority, birth or other status that negatively affects the dignity of men and women.

e) Sexual Harassment – Unwanted conduct that is perceived by the victims as placing conditions of a sexual nature on their employment, or that might, on reasonable grounds, be perceived by the victims as an offence, a humiliation or a threat to their well-being.

f) Bullying/mobbing – A form of psychological harassment by an individual or a group, consisting of persecution through vindictive, cruel or malicious attempts to humiliate or undermine another individual or groups of employees, including making unjustified, constant negative remarks or criticisms, gossiping or spreading false information, thus isolating a person from social contacts. (2003, p.2)

All of these behaviour descriptors fall under the theme of intercollegial violence as described in the Saskatchewan Registered Nurses Association's NewsBulletin (SRNA, 2009).

It is suggested by di Martino (2003) that stress and violence in the workplace involve many factors such as:

a) Coronary-prone personalities (type A), of which there is a high ratio in the healthcare sector, who exhibit: i) high achievement needs yet undefined goals; ii) high competitiveness; iii) strong desire for recognition; iv) consistently engaging in multiple projects and functions; v) pushing one's physical and mental abilities; and vi) demanding oneself to stay hyper alert for long periods.

b) Perpetrators who have a history of violence, psychotropic substance abuse (especially alcohol) and serious mental illness not diagnosed but who have access to situations that can lead to interpersonal violence.

c) Victim attributes such as health, appearance, age, gender, experience, personality, attitude, temperament, and expectations.

d) A heavy workload which in turn causes stress on the workers which may lead to misleading behaviour and misunderstandings which then potentiate aggressive communication.

e) Gender issues and the fact that most healthcare workers are female; as well, female workloads tend to be much higher than male workloads.

f) General environmental issues, such as safety hazards can trigger direct or diffuse violence.

g) Poor organization that leads to an increase in workload.

h) Change issues such as restructuring, decentralization, downsizing, job insecurity and the use of temporary employees have serious effects on workplace stress and workplace violence.

The book, *I Thought It Was Just Me: Women Reclaiming Power and Courage in a Culture of Shame* (Brown, 2007) deals directly with shaming behaviours. Brown indicates that North America, as a culture, tends to approve shaming behaviours as a means of getting needs met (Gossen & Anderson, 1995; Rosenberg, 2006). It would appear that nurses in North America also use shaming behaviours as a vehicle for developing self-protection, gaining alliances, answering power/autonomy needs, increasing self-esteem, and sometimes simply as a source of entertainment (Farrell,

2001). Such communication styles that promote or continue shaming, lead to problems in the workplace.

According to the RNAO (2009) document, of all healthcare professionals and providers, nurses experience the most workplace violence. So how can we create a respectful and caring culture within our practice setting in view of growing evidence of abusive and oppressive workplaces that demoralize and denigrate nurses who love nursing yet loathe their workplace? Most importantly, “how can we move solidly beyond our compelling rhetoric supporting ‘zero tolerance’ into actions that prevent and mitigate violence toward nurses?” (2009, p. 32).

Prevention and Interventions for Intercollegial Violence

The health-sector literature details a wide variety of interventions for all types of violence in the health sector, but the interventions that I will address in this project are designed specifically for intercollegial violence. These interventions derive from literature specific for the healthcare sector and literature from other fields that are also engaged with workplace communication challenges.

The RNAO developed a document, *Healthy Work Environments Best Practice Guideline: Professionalism in Nursing* (2007) and one of the sections from this document speaks to collaboration, collegiality, and professionalism. The best practice guidelines from this document suggest that nurses who engage in positive patterns of communication, enhance teamwork and voice their issues and concerns, support a quality workplace environment. The RNAO states, “The commitment that nurses feel towards patients should extend to commitment to one another. Collegiality, such as taking part in professional organizations, mentoring, role modelling, assisting researchers is an

important professional attribute (2007, p.40). The following strategies to ameliorate intercollegial violence were found by RNAO in the literature and were validated by an expert panel:

a) Value colleagues through supporting behaviours such as assisting one's colleague with a complex assignment.

b) Design and implement processes in the work environment that promote team building, respecting other colleagues and recognizing achievements.

c) Find methods to improve the practice area.

d) Design and implement a preceptor and/or mentor program.

e) Initiate and participate in inter-professional, interdisciplinary, and cross-organizational networking and education.

f) Initiate and implement peer review and recognition programs that recognize professionalism and excellence.

g) Respond to and support colleagues who are experiencing challenges in their practice through dialogue, advocacy, and problem solving.

h) Support colleagues who articulate issues and problems in the professional practice and assist in the resolution of such issues.

i) Respect the organization's values, mission and vision.

All of these suggestions can be facilitated at an individual nurse level.

According to the RNAO (2009) document, *Healthy Work Environments Best Practice Guidelines: Preventing and Managing Violence in the Workplace*, there are several recommendations for prevention of and intervention in workplace violence. The document stresses that workplace violence is a very complex matter and that nurses in

particular bear the brunt of this workplace trauma. Studies show that poor working conditions, workload issues, and domestic violence transferred into the workplace are contributing factors. Because of this complexity, the RNAO, Occupational Health and Safety Act, and the Government of Canada agree that addressing workplace violence in the health sector requires addressing the root causes. Therefore, responsibility is required at many levels in order for prevention and intervention to achieve a depth of efficacy. These levels include governments, researchers, accreditation bodies, education agencies and programs, professional organizations, union and regulatory bodies, and service organizations.

Kushnir Pekrul (1992) was one of the first nurse researchers in Saskatchewan to identify that nurses need to be educated to learn how to put a stop to abuse directed at them. The RNAO (2009) document suggests that nurses do not have the preparation or skill to handle the many forms of violence that are thrust upon them. Workplace violence is a learned behaviour (Lewis, 2006) and therefore ongoing education programs for nurses are required if they are to identify and diffuse such behaviour. Prevention is the ultimate goal and learning interventions are of paramount importance when violent behaviour emerges. Prevention strategies suggested from the RNAO (2009) document related to the individual and teams are:

a) promoting professional respect, improving working relationships and advocating a workplace free of violence;
b) encouraging nurses to be self-reflective and self-aware in their behaviour and understanding the reasons for their behaviour;
c) educating nurses to understand how their behaviour impacts others;

d) supporting nurses who have been victims of or have witnessed workplace violence;

e) providing services for debriefing the nurse after a violent situation and assisting in the redevelopment of trust with regard to co-workers and employer (e.g. "...nurses who have experienced bullying, they may be encouraged by adapting such coping strategies as engaging in positive self-talk, emphasizing their intent to maintain their own integrity, engaging in stress-releasing activities, and accessing both formal and informal sources of support" (RNAO, 2009, p.54)); and

f) providing awareness education for everyone in the workplace to help the culture move towards a violence-free environment.

Intervention strategies for the individual and for teams faced with intercollegial violence are:

a) nurses take action when they have experienced bullying, such as reporting to the manager and initiating grievances or seeking out support from friends and other colleagues; and

b) nurses participate in a collaborative practice of problem solving and developing common values, practices and responsibilities.

Since *Focusing* is a powerful way of encouraging people to be self-reflective and aware of their behaviour and to gain understanding and adaptive strategies, it is likely that *Focusing* would be an asset and would complement the above prevention and intervention strategies.

The CNA Code of Ethics (2008) document is an intervention in itself for intercollegial violence as it stresses that nurses should practice daily ethical behaviour. As well, the code is consonant with the RNAO (2007, 2009) documents for healthy work environments and the prevention of workplace violence in the healthcare sector.

The 2003 working paper by di Martino provides strategies for coping with workplace violence and suggests that a broad spectrum approach be taken with stress and violence in the workplace. He encourages healthcare sector workers to consider all the causes that provoke stress and view these problems not from an individual, structural or strategic position, but from an even wider perspective. He states that stress and violence at the workplace is "...rooted in wider social, economic, organizational and cultural factors" (2003, p. 26). It is necessary, he insists, for a manager to become a "violence-conscious manager" (2003, p.26). Prevention needs to happen at an organizational level rather than at an employee level to improve working conditions. However, addressing this critical worldwide workplace violence is necessary for both the development of the individual and the organization.

Social dialogue has been shown to reduce workplace violence. Such a dialogue diffuses work-related violence and stress and commits all parties involved to an active participation in ongoing anti-violence and anti-stress initiatives. One such dialogue, the Socratic dialogue, has been useful in group conversation as well as with one-on-one interactions and provides safety within the communication process (Brown & Isaacs, 2005; Fitzgerald & van Hooft, 2000) in that it offers a less stressful way to talk about things that matter. The key principles for one such approach, the World Cafe' Socratic dialogue, are:

a) state the purpose and set the parameters;
b) provide a welcoming and psychologically safe space that supports mutual respect and nurturing;
c) explore important questions that matter and encourage engagement;
d) invite full participation towards a to-and-fro dialogue;
e) facilitate diverse perspectives while maintaining the original focus;
f) listen for deeper questions, patterns, and insights; and
g) harvest the collective wisdom, making wisdom visible and ready to put into action.

Fritzgerald & Hooft (2000) in their research project suggested that the Socratic dialogue is a method which allows nurses to become explicit in their morals and ethics, and thereby, their decision making. As the authors stated, "...a Socratic dialogue conducted with nurses on the topic: 'What is love in nursing?' were based on the belief that the current western-style healthcare system restricts the practice of nursing in such a way as to limit professional caring and loving possibilities" (p. 481). Although this article primarily talks about loving the patient, it makes the clear point that the Socratic dialogue between nurses in the workplace has the potential to increase their caring for one another (RNAO, 2009).

The book, *Peace and Power: Creative Leadership for Building Community* (Chinn, 2008) outlines a variety of skills consistent with building positive collegial relationships (RNAO, 2009). Chinn's book draws attention to the balance of power among colleagues, which is vital for the successful intervention of intercollegial violence, thereby enhancing the quality of nursing workplace environments.

Respect is the hallmark for an ethical relationship (MNA, 1999). The MNA position statement emphasizes that nurses should embrace ethical practice, which includes fostering high-quality relationships among nurses. Respect is important for developing collegial relationships and is essential for preventing intercollegial violence.

Literature Research in Other Disciplines

In order to calm a potentially violent situation, nonviolent communication and restitution are two interventions that address the phenomena of human needs in psychology, control theory and counselling theories (Gossen & Anderson, 1995; Hinterkopf, 2010; Rosenberg, 2006). Rosenberg, Hinterkopf, Gossen, and Anderson all suggest that, when needs and demands are heard, individuals feel validated and relationships and workplaces become healthier. The training in and application of nonviolent communication will enable individuals to express their needs without receiving harsh judgement (Rosenberg, 2006). Judgements happen in nursing workplace environments when nurses, who require safe, respectful, collegial relationships, are marginalized and criticized harshly when this need is expressed (CNA, 2008, 2010; di Martino, 2003; RNAO, 2009).

The concept of restitution is based on similar values as that of nonviolent communication, where addressing the needs behind behaviour can lead to healthier relationships and workplaces (Gossen & Anderson, 1995). Restitution suggests that punishment for unwanted or inappropriate behaviour does not help relationships or workplaces. Gossen and Anderson suggest that individuals need opportunity and choice in order to repair relationships. Restitution offers both, and goes beyond the lip service of an apology and can facilitate many possible approaches toward repairing broken

promises, poor behaviour, disrespectful communication, etc. Restitution requires respectful dialogue between the offender and the offended to negotiate the restitution process.

In their interpretive phenomenological research paper, Fletcher and Milton (2010) discover that there is a difference between healthy and pathological aggression. Briefly, a key theme that emerged from this research study was that aggression channelled appropriately, much like electricity, will bring about healthy behaviour and/or illumination; whereas, uncontrollable aggression (as with lightning) can bring about destruction. Once a person learns how to facilitate aggression in a constructive way, possibilities, choices and new ways of engagement open up for her.

Literature Research on *Focusing* as Potential Intervention

The article *Focusing and Caring Touch: Teaching Nursing Aides in a Long Term Care Setting* (within the healthcare sector) described an improved work and living environment for both residents and staff after the education in and preparation of *Focusing and Caring Touch* (McGuire & McDonald, 1999). Due to the aging process and the experience of being institutionalized, the residents are at risk of presenting behaviour management problems for their care providers. The authors address the residents' and staff's need for love and belonging and both groups experienced a positive change in quality of work and quality of living in their long term care setting (Gossen & Anderson, 1995; Hinterkopf, 2010; Rosenberg, 2006).

Focusing in Changing Abusive Fighting to Constructive Conflict Interaction: RWV Therapy with Domestically Violent Men (Bierman, 1999), describes a psychotherapist's use of *Focusing* to change emotionally abusive behaviour into

constructive interactions in the context of a partner relationship. What is vital for the purposes of this research project is that Bierman (1999) recognizes that the shame-rage cycle is a key pattern in emotionally abusive interactions.

Wagner (2006) identified experts who integrate *Focusing* in their counselling services when assisting people with post-traumatic stress disorder caused by trauma related to war, accidents, sexual and physical abuse, emotional abuse and neglect. For example Turcotte (2011) works with Aboriginal communities (and other races) using a medicine wheel as an assessment tool but also uses Focusing Oriented Therapy to help people heal from trauma in their life (personal communication and training from Turcotte, 2011). Further, Levine (1997), a respected trauma expert, uses "Somatic Experiencing" when working with people who have experienced trauma. Somatic Experiencing is very similar to *Focusing*. As Levine states, "The felt sense is a medium through which we experience the fullness of sensation and knowledge about ourselves" (1997, p.8). He is clearly using the felt sense, just as *Focusing* and this research project do. I have not found any research on *Focusing* as an intervention for workplace violence for nurses.

Summary of Literature Review

In summary, this literature review has documented the extent to which the WHO, RNAO, SRNA, CNA, CFNU, ICN, ILO, PSI consider workplace violence in nursing practice settings to be a major issue. The literature also encourages all levels of the healthcare sector to address this serious issue. The review speaks to preventions and interventions of intercollegial violence largely in the nursing literature. There is also a review of interventions from other disciplines, such as psychology, counselling and

philosophy theories, used to calm a potentially violent situation. The last area of the literature research looks at *Focusing* as a potential intervention at an individual level: one with long-term care aides and the other with domestic violence with men. This review has revealed a gap in the literature in that no research has examined *Focusing* as an intervention with intercollegial violence in nursing workplace settings.

Chapter Three: Research Methodology – Hermeneutic/Interpretive Phenomenology Research Design

Methodology

In this study, I used hermeneutic phenomenology (Interpretive Phenomenological Analysis: IPA) to explore nurses' experience of intercollegial violence in their workplace. Phenomenology can be understood as the study of the human being's experiential life world (Fjelland & Gjengedal, 1994) or "the study of the lifeworld – the world as we immediately experience it pre-reflectively rather than as we conceptualize..." (van Manen, 2003, p. 9). In this case, IPA studies the "human lived experience" (Shinebourne, 2011, p. 28) examined through the researcher's and co-researchers' (nurses participating in the research) self-interpreted data. These meanings give possibility to the embodied, existential, cognitive and emotional domains as well as to the physical, spiritual and psychological dimensions of a human life. Humans live by doing things in their world. Humans self-reflect on their doings and those human doings have existential and meaningful consequences. Through the application of IPA the researcher and co-researchers gathered results based on the nurses' experience of an embodied human beingness (Dreyfus, 1994).

Human curiosity leads to self-understanding and self-interpreting, which opens the individual human being to a variety of possibilities, choices and responses to their world (Dreyfus, 1994). According to Martin Heidegger, each human being experiences a unique way of being through which "actions follow from (her/his) self-interpretation" (Dreyfus, 1994, p. ix). The writings of Heidegger are the foundation for Interpretive Phenomenology (Leonard, 1994). Heidegger wants to ask, "What it means to be a person and how the world is intelligible to us at all?" (Leonard, 1994, p. 45).

Leonard suggested that research nurses use “a multiplicity of methods” (1994, p. 45) toward the understanding of being human with respect to individual capability and suffering (Cassell, 1999; Egnew, 2005). In this research project, I brought a “multiplicity of methods” to bear on intercollegial violence and the individual capacity to resolve such workplace violence. For example, asking the co-researcher to describe his/her intercollegial workplace violence through a metaphor is one method of capturing the essence of the co-researcher’s self-interpretation of workplace violence. Another method was that of storytelling (Stone, 2004): as a researcher, I listened to and reflected back on the co-researchers’ stories related to their workplace violence experiences.

Heideggerian phenomenologists move beyond traditional science and theory that, for them, limits a full understanding of human capability, suffering, concerns, goals, purposes and commitments. Heidegger was concerned that research questions would be limited or constricted (Leonard, 1994) in terms of what “being” means for the human. As a result, to understand what “being” means for the nurse experiencing workplace intercollegial violence, I did not limit or constrict the study questions; instead, I was interested in gaining insight into and understanding about nurses’ concerns, habits, actions and stories as they shared their burden concerning intercollegial violence (Dreyfus, 1994). I was interested in what it might be like for the nurse to be in that world (workplace environment) and how the use of *Focusing* would affect a nurse’s everyday work when coping with suffering?

The Heideggerian understanding of a person involves five main facets (Leonard, 1994, pp. 46-54) and these have helped me gain insight into the everyday lived experience of a person. The five facets of a person are:

1. That the human experience is of having an *a priori* world: An *a priori* world means that the human is born into and therefore situated in a culture, language, and history already present. This world provides shared practices and skills which gives intelligibility and meaning to human choice. Therefore, according to Heidegger, the world has a great influence on human purpose and value and so humans do not have ultimate say over their own identity.
2. That the human being cares about things that matter: Things have value and significance (objects, projects, goals, practices and commitments) but these things are also connected with feelings (shame, guilt and dignity) and desires.
3. That the human being is self-interpreting in a non-cognitive and non-theoretical way: humans are always engaged in self-interpretive understanding, they interpret what is happening and what is going on. Heidegger suggests that such self-interpretations are drawn from the existing cultural and linguistic traditions, thus there are no absolute facts: "Nothing can be encountered independent of our background understanding" (Leonard, 1994, p. 52).
4. That the human being is embodied: In other words, "...rather than having a body, we are embodied" (Leonard, 1994, p. 52). Choices and common practices for self in the world are mediated through the body and are based on the body's perceptions and perceptual capacities. It is the body that

perceives and moves through the world with meaningful intention. The body is the living centre that provides existential possibilities.

5. That the human being is a being in time: Heidegger's term is temporality ("the past as 'having-been-ness'" (Leonard, 1994, p.53)), or time that is always moving into the future. Temporality has dimensional content, is characteristic of transition and is full of activity needing attention or concern from the human being. Temporality belongs to a being, not to objects and is relational and directional.

I thank Heidegger (2010) and Leonard (1994) for the phenomenological description of the five facets of a human being. Through the experience of interpreting the data and the themes that emerged from the data, I have modified these to become the *Six Facets of a Human Being Assessment*, insofar as this meets my way of being with the client and interpreting his/her experiences as a researcher, counsellor, and nurse, as well as being with groups of people when teaching *Focusing*. The *Six Facets of a Human Being Assessment* will be further described in the Implications Chapter (please see Figure 3, p. 142).

This research project examined nurses' experience of intercollegial workplace violence and their experience(s) before and after they were exposed to an experiential workshop on *Focusing*. *Focusing* was studied as an intervention for nurses faced with intercollegial violence in their workplace environments. One of the aims of the project was to learn whether *Focusing* could help the co-researchers to prevent, resolve, transform, or transcend their intercollegial violence experiences.

Method.

As the researcher, I have analyzed each of the co-researcher's self-interpretations regarding her/his experience of intercollegial violence in their nursing workplace before and following his/her preparation and practice of *Focusing*. Every effort was made to avoid trivializing, destroying, de-contextualizing, sentimentalizing or distorting the nurses' everyday practices or experiences (Leonard, 1994).

Design.

The design of the study involved situating the IPA within a descriptive approach, namely, "One Group Pre-test-Post-test Group Design" (Mertens, 2010, p. 133). The design had three major stages: i) a Pre-*Focusing* Workshop Interview (Pre-FI); ii) participation in a *Focusing* workshop; and iii) a Post-*Focusing* Workshop Interview (Post-FI).

Procedures.

Co-researcher selection.

The term 'co-researcher' is equivalent to the label 'nurse'. Co-researcher was chosen because it is the individual's lived self-interpreted experience of workplace violence that is central to this thesis project. Co-researchers were self-selected through their response to the researcher's advertisement (please see Appendix A). The advertisement was placed in a Saskatchewan Registered Nurses Association (SRNA) email and sent to the SRNA Workplace Representatives in their nursing practice settings. The email had a target of 9,900 nurses (personal communication, SRNA, May 1, 2009). The Saskatchewan Union of Nurses (SUN), declined to place the researcher's advertisement in a *SUN Spots* issue because I was not a member. However, the

Registered Psychiatric Nurses Association of Saskatchewan sent the advertisement out with one of their membership surveys, and the response from this was fruitful; I recruited two nurses from this mail out. The Saskatoon District Health Board refused to let the researcher post the advertisement in any acute or long-term care facilities. The long-term care facility contact person stated that I would need to apply to the University of Saskatchewan for another ethics proposal, which would take considerable time; plus there were no guarantees that they would accept the proposal. I had already received ethics approval from St. Stephen's College. Recruiting Registered Nurses, Psychiatric Nurses, and Licensed Practical Nurses was a challenge since workplace violence in nursing practice settings and in healthcare agencies in Saskatchewan is a sensitive issue. In fact, when I inquired at an acute care setting about posting the advertisement there was no response.

The procedure for accepting co-researchers involved initially conducting a preliminary screening interview by telephone to explore each nurse's experience of intercollegial workplace violence. This preliminary screening interview consisted of: a) asking a set of questions (please see below and Appendix B); b) explaining the research project process; c) explaining *Focusing* and describing the *Focusing* workshop; d) asking the nurse if he/she would be interested in participating in a *Focusing* workshop; and e) explaining confidentiality and ethical behaviour on the researcher's part.

The questions asked in the preliminary telephone screening interview were based on the SRNA (2008) document that speaks to intercollegial violence. This document identified the following shaming behaviours: breaking confidences, infighting, scape-goating, lack of respect for privacy, non-verbal posturing, withholding of information,

verbal affronts, backstabbing, undermining activities, and sabotaging other colleagues (Brown, 2007; see Appendix B). These shaming behaviours formed the basis of the questions that were subsequently developed.

As a result of the research project advertisement, ten people contacted me. One was not a nurse but expressed interest in participating. Three individuals resided in other provinces. Seven nurses expressed or shared feelings of shame, humiliation or embarrassment to one or more of the screening questions during the telephone screening interview. These nurses were invited to join the researcher as co-researchers for the purpose of this research study. Two of the seven nurses subsequently withdrew from the project. One nurse indicated that she was too busy after the Pre-*Focusing* workshop interview to continue to participate and the other did not respond to the researcher's calls after the Post-*Focusing* workshop interview. Five nurses willingly completed the entire research project and all expressed gratitude and appreciation for the research process and the *Focusing* workshop. These five co-researchers practiced in various areas of Saskatchewan, in both urban and rural settings. They also had various levels of nursing preparation: one was a Licensed Practical Nurse; two were Registered Psychiatric Nurses; and two were Registered Nurses.

The nurses who responded with a 'Yes, I will participate' during the preliminary telephone screening interview were given an in-depth explanation of what the research project would entail and what was required from them. Before the Pre-*Focusing* interview, the following was read and explained to them during the researcher's initial face-to-face meeting: a) an Information Letter, b) Instructions for the Co-researcher; and

c) an Informed Consent form. At the Pre-*Focusing* workshop interview, I witnessed the signing of the Informed Consent form by each co-researcher.

Data collection.

Prior to the current research project, the researcher facilitated a pilot study with three nurse colleagues to hone researcher's facilitation skills. Data collection for the current research project consisted of a series of interviews. The interviews were conducted before the *Focusing* Workshop (Pre-*Focusing* Workshop Interview) and after the *Focusing* Workshop (Post-*Focusing* Workshop Interview), and were taped and transcribed by a professional transcriptionist who signed a confidentiality form. Since the researcher provided the *Focusing* workshop, the Post-*Focusing* Workshop Interviews (questions shown in Appendix C) were conducted by an independent third party (a nurse colleague) to minimize the demand characteristics of the situation.

The interviews were semi-structured in nature which gave the nurses/co-researchers the opportunity and choice to provide as much information as possible regarding their experience(s) of intercollegial violence before and following the *Focusing* workshop. The interview questions focused on listening for a metaphor, a story or a description of a picture that may describe his/her intercollegial violence experience (please see Appendix C). A metaphor is defined as "something that stands for something else" (Combs & Freedman, 1990, p. xiv) and can form a brief story from which the individual can learn. Each of the co-researcher's metaphors were first identified in the Pre-*Focusing* Workshop Interview and then examined again in the Post-*Focusing* Workshop Interview to assess if there had been modifications in the metaphors which

might indicate some improvement of the co-researchers' understanding of their situation or improvement of the situation itself.

Metaphors are ideal for this project because they can be rich, multi-levelled, carry significant meaning and symbolize a co-researcher's experience. The metaphorical experience can also assist in making the implicit experiences explicit, which is transformative in itself and may lead to an unpredictable transformation (Madison, 2010). The most significant reason for using metaphors is clearly articulated by Banonis (1999): "Human language is replete with metaphors and symbols which offer creative gateways to understanding lived experiences of health" (p. 87). Parse (1999) suggests that metaphors and/or symbols are ways for humans to express their unique ways of making meaning of their lived experiences that surpass daily language. Gendlin (1985) suggests that a metaphor is closely related to an individual's imagination which forms a large part of his/her world. Imagination creates metaphors and metaphors transcend words and give the researcher "an image-picture" (p. 384).

Data collection took place during two phases of this research project (the metaphoric phase and interview phase) and two different points during the research project (pre- and post-*Focusing* workshop). The Post-*Focusing* workshop metaphor and interview phases were conducted from three to four weeks following the *Focusing* workshop so the incubation period between the workshop and the Post-*Focusing* interview was the same. This time period gave the co-researchers adjustment and self-reflection time.

Digital recorders were used to audio tape what the co-researchers said during both Pre- and Post-*Focusing* workshop interviews. Following the Pre-*Focusing* interviews, I

listened to the metaphors shared by the co-researchers and recordings were transcribed. The transcriptions of the exact wording of the recordings were provided to the nurse colleague interviewers who then read the metaphor back to the appropriate co-researcher at the beginning of the Post-*Focusing* workshop. This gave the co-researchers an opportunity to state whether their metaphor had changed since the *Focusing* workshop. Standardized, semi-structured questions were asked by the researcher during the Pre-*Focusing* workshop metaphor and interview phases. Standardized questions were asked by the nurse colleague interviewers during the Post-*Focusing* workshop interviews (please see Appendix C).

Data analysis.

The amount and the intensity of data gathered during this research project were overwhelming. IPA can be understood as the study of the human being's experiential world as it tends toward self-interpretation and interpretation by researchers such as myself, including both "... subjective experience and personal accounts" (Shinebourne, 2011, p. 17). I was concerned with the co-researchers' constructed meanings as they manifested in different spheres personally and socially as well as emotionally, psychologically and spiritually. In other words, through the application of IPA, the co-researchers and I gathered results based on the nurses' experience of an embodied human being-ness (Dreyfus, 1994).

I, as the researcher and as an embodied human being, analyzed the results, also through the application of IPA. Todres and Galvin (2008) state, "Embodied interpretation is a body-based hermeneutics in which qualitative meanings are pursued by a back-and-forth movement between words and their felt complexity in the lived body" (p. 575).

The data was transcribed word for word and analyzed through various steps, including repeated review of the taped interviews and multiple readings of the transcriptions.

All metaphors or pre-metaphors (the description of a situation that suggested a metaphor yet stopped short of an actual metaphor) were thematically analyzed in both the Pre- and Post-*Focusing* phases. Gendlin suggests that one's body feels and lives a holistic knowing of a sort that is aesthetic in nature (Todres & Galvin, 2008). Metaphors (aesthetic in nature) collected through the co-researchers' embodied self-interpretation are images of their worlds and imaginations, meaning that they are larger than words, yet can find words. Lived metaphoric experience becomes larger than life; therefore, by examining metaphors, I could follow the transformative processes in all five co-researchers.

Following the metaphor phase of the analysis, the remaining interview data was colour coded to sort out the various similarities in phrasing. Similar phrases were then clustered into 12 different groupings on flip-chart paper. The groupings were further divided into themes and sub-themes. Through the deep self-reflecting process of *Focusing*, I self-interpreted patterns of knowing (Todres & Galvin, 2008) that surfaced in the major themes.

I analyzed the themes and the sub-themes once again using an embodied interpretation of the co-researchers' self-interpretation of their workplace violence experience. Implications of the Six Facets of a Human Being assessment were explicated as they emerged from the co-researchers' data and themes.

Validity.

To maintain validity, I digitally taped the Pre- and Post-*Focusing* workshop interview sessions. I also proofed the transcribed tapes verbatim and checked the transcriptions against the taped interviews. Two methods were used to validate the data: a) the exact transcripts from the co-researchers' interviews were used to formulate the themes and sub-themes; and b) direct quotes from the transcripts were used to support any analysis. Further, the co-researchers read and approved the transcripts prior to data analysis and its division into themes. The co-researchers also read the storyettes, metaphors, findings, discussions, and implications, and gave approval of these.

The researcher followed the guidelines for assessing the quality and validity in qualitative research as described in Shinebourne (2011). These guidelines included sensitivity with the context of the project, rigor and commitment, and coherence and transparency.

Sensitivity with the context of the project.

By choosing IPA as a method of examining data, I maximized sensitivity to the socio-cultural milieu of the nursing practice settings, as discussed in the vast literature about workplace violence in the healthcare sector. I remained sensitive to each co-researcher's history, culture, and his/her own individual experiences and especially the way she/he self-interpreted the experiences. Further, I was committed to caring about every detail of the data throughout the analysis. My interpretations were grounded within the co-researchers' self-interpretations of their workplace violence experiences. Verbatim quotes from the co-researchers are presented along with supporting material from the literature. The co-researchers maintained an essential voice in the text – something very

dear to my heart. The metaphoric phase of the project with its image-like language gave the co-researchers an opportunity to directly convey to me the nature of the intercollegial workplace violence they experienced. This in turn gives the reader the opportunity to assess the interpretations I have made, as well as to self-interpret with regard to the text.

Rigour and commitment for the project.

I engaged in prolonged back-and-forth interactions with the co-researchers' data throughout the analytical stage of the project, and was meticulous and methodical when assembling the quotes for each sub-theme. This was a qualitative project involving five co-researchers, five Pre- and Post-*Focusing* metaphoric themes, and five Pre- and Post-*Focusing* interview themes. From each theme in the interview, sub-themes emerged through self-reflection and self-interpreting processes. It was necessary for each co-researcher to read and revise, delete or accept the raw data, and to read and revise or accept the researcher's findings, discussions and implications. As well, I facilitated a pilot project to practice my interviewing skills and to assess how the semi-structured questions would work when learning about the co-researchers' intercollegial workplace violence experiences.

Coherence and transparency within the project.

All of the co-researchers went through the exact same phases, stages, procedures and steps of the thesis project (these were all clearly outlined under the Procedures section). In addition, the selection of the participants and development of the semi-structured interview, and deciding who would conduct the interviews and who would teach the *Focusing* workshop, were all carefully articulated. The stages of the analysis were clearly described. Theories related to the data and themes, the five facets model,

metaphoric phase and interview phase were carefully researched and integrated. The research question was set according to the hermeneutic phenomenology because I wanted to extend understanding of the self-interpretation of the co-researchers' intercollegial workplace violence experience. In fact, the researcher provided two to five quotes from the co-researchers within each subtheme to present their perspective on their experiences. The data from all five co-researchers was studied collectively to follow trends and patterns, "therefore manifesting the interpretative activity of IPA" (Shinebourne, 2011, p. 27).

The researcher took into account the imagined reader when reflecting and writing the interpretation of the workplace violence experiences. The researcher asked frequently, 'Does this sound valuable, interesting, useful or important?'

Triangulation builds trustworthiness into the research project (Mertens, 2010). I drew from many literature sources to support the research project. Examples of triangulation are: a) similarities in findings from other research projects related to intercollegial workplace violence in nursing practice settings; b) sourcing support from the literature to enhance discussions in the Findings and Discussion chapter; and c) including research, position statements, guidelines and recommendations from several sources that speak to the seriousness of workplace violence in the healthcare sector. The use of multiple sources, "evidence across sources of data" (Mertens, 2010, p. 258) and drawing from both qualitative and quantitative approaches strengthens the research project, adds to consistency, provides fact checks and improves validity. The literature review assisted me immensely in supporting the analysis, as did adding new literature. I had an external reader scrutinize the text, giving credibility to the findings and the

methodology. Most importantly, I had the co-researchers provide feedback on the accuracy of the quotes and the findings, ensuring that their voices were articulated with clarity and congruence in terms of their own embodied self-interpretation of their workplace violence experience. I continually asked the co-researchers if I understood correctly what their experiences were, and I verified any beliefs I had about what they were saying. I also returned repeatedly to the transcripts to review my interpretations of what was shared by the co-researchers during the interviews.

Importance and impact of the project.

Validity needs to be assessed by a third party or external reader. I suggest that this thesis project will be useful to many professional communities, such as the nursing community, the *Focusing* community, the counselling and psychology community, and the healthcare sector in general.

Evaluation.

Evaluation of the IPA study is not a straightforward affair. As the interpreter (researcher) of the self-interpreting co-researcher's experience, I needed to have an evaluation process in place to validate the accuracy of the data and to avoid bias, simplifying, trivializing, destroying, de-contextualizing, sentimentalizing or distorting the analysis. However, when working with a hermeneutic/IPA approach, Leonard suggests that "...there is no such thing as an interpretation-free, objectively 'true' account of 'things in themselves'..." (1994, p. 60). As well, there is no scientific technique for validating the 'truth' in interpretive phenomenology. One validating technique recommended by Giorgi (2010) is for the researcher to share the findings with the co-researchers so that the co-researchers can compare their experiences with the researcher's

analysis. Leonard (1994) suggests that the research be facilitated with concerned, practical engagement, meaning that Interpretive Inquiry seeks not only to describe the particular phenomena; rather "...it is concerned with the breakdown in human affairs..." (Leonard, 1994, p. 60) such as workplace violence in nursing practice environments. Therefore, this study evaluated the degree to which the breakdown in communication (intercollegial violence) in the nurse's workplace was resolved and posed the question: was there an opening to new ways for the nurse to engage in her/his workplace? In other words, as the researcher, I was and am interested in learning if the nurses who received the *Focusing* workshop experienced resolution or other possibilities that had an impact on their workplace violence experiences.

Researcher as Interpreting the Self-Interpreting Co-Researchers

Heidegger views "hermeneutics as a prerequisite to phenomenology" (Shinebourne, 2011, p. 18) and suggested that the phenomena being studied needed the opportunity to be brought into the light, be illuminated, be uncovered, or be revealed. The hermeneutic approach uncovers meanings hidden in the individual's phenomenological lived experience. IPA, a phenomenological hermeneutic inquiry, is "an interpretative process" (Shinebourne, 2011, p. 18) which explicates (illuminates) the meaning of the phenomena being studied. As the researcher, I suggest that through different layers of self-interpreting, through the intervention of *Focusing*, the co-researchers' experience of intercollegial workplace violence was excavated to reveal the intense and excruciating experience of suffering. Alongside this was the hope that this process would help direct their suffering into various healing pathways.

Humans engage in a self-interpreting process and are realized and recognized by their interpretative understandings. Our interpretations are grounded in our cultural and linguistic traditions; therefore, self-interpretations come out of the individual's an *a priori* world (another facet of a human being). All five of the co-researchers self-interpreted, as nurses, their lived meaning of intercollegial workplace violence as an embodied experience. The co-researchers' understanding of their experience is directly related to the nursing culture and enabled by the culture's language (Shinebourne, 2011). Suffering was illuminated, uncovered, revealed, and brought into light by my interpretation of the co-researchers' self-interpretations of their intercollegial workplace violence.

Limitations of the Thesis Project

Transparency gives credibility to the researcher and the research project. One limitation of this project was produced by the challenges in recruiting co-researchers. Perhaps the project could have recruited a more diverse collection of co-researchers if there had been more exposure to the advertisement. Differences among the co-researchers may have been a limitation. Some of the co-researchers were in the midst of workplace violence and some were sharing past workplace violence experiences (which they struggled and suffered with during the research project). The difference between understanding a human process over time and being immersed in the traumatic event might create a strong limitation or sway the findings of the project. Another limitation for me was the policy on how many pages the thesis could use to present its ideas (i.e. 150 pages did not seem enough for the enormity and intensity of the data).

I stayed true and committed to the methodology of hermeneutic interpretive phenomenology, keeping in mind that there is no stepping back from my embodied self-

interpretation of the data (Shinebourne, 2011). I maintained an engagement with the co-researchers' lived meaningful experiences of workplace violence and wanted to know, from the co-researchers' perspectives, what it was like to be a human being experiencing such incredible suffering. IPA is by definition the project of human beings embodied in their lives in a particular historical cultural and social context. Therefore its question: "What does it mean to be a person?" (Leonard, 1994) forms a distinctly different approach than that of Husserlian phenomenology (Shinebourne, 2011). This approach has led to controversy in the literature about IPA and its very personal process of exploration (Giorgi, 2010): e.g., the researcher self-interprets the self-interpretation of the co-researcher's experience. There is no bracketing, no objective, rational splitting of fine hairs in IPA's approach (Smith, 2010).

Before leaving this discussion, there is one other limitation, that of taking a qualitative rather than a quantitative approach. From that paradigm, I was cognizant that this research is a single group study with a pre-test/post-test design that has no control or comparison group (Mertens, 2008). Therefore, when seeking the reason for changes, the design is vulnerable to threats of maturation and history. The co-researchers may have experienced maturational changes or external events that could have influenced the observed changes. However, a strength of this research project resides with the intervention *Focusing*. I suggest to the reader that *Focusing* works at any embodied time of the human beings' lived experience. *Focusing* works with the long past and the fresh present and with remoulding the future (Madison, 2010). In other words, there is strong support from this project that *Focusing* works toward promoting adapting, transformation

and resolution regardless of the proximity of the event (workplace violence) to the intervention.

Chapter Four: Ethical Considerations

This thesis project involved human subjects and therefore required a review and approval by a Research Ethics Committee (REC). I presented an Ethics Application to the REC that honours the policy statement from St. Stephen's College, Edmonton, Alberta, according to the Master of Psychotherapy and Spirituality program manual. The ethics application included three copies of the researcher's Thesis Project Proposal, Advertisement (Appendix A), Preliminary Telephone Interview (Appendix B), Pre- and Post-*Focusing* Interview Questions (Appendix C), Letter of the Purpose of the Research Project (Appendix D), Instructions to the Co-researcher (Appendix E), Informed Consent (Appendix F), Confidentiality Form for the Transcriptionist (Appendix G), and Confidentiality Form for the Second Interviewer (Appendix H). A copy of the ethics form can be found in Appendix J.

Research ethics reflect concern for the protection of both the co-researchers and the primary researcher (myself); hence the confidentiality forms for the transcriptionist and the second interviewer. To further ensure the safety and confidentiality of the co-researchers, the transcripts and files containing their screening interview forms and consent forms are contained in a locked box to which only I have access. St. Stephen's College has no specific time length for retaining data but once the research project is complete, and with final approval of this project, I will destroy the data, tapes and files. This procedure was explained to the co-researchers. Great care was taken to protect the identity of each co-researcher. For final reports, summaries, future conferences or publications, the researcher will maintain the protection of the co-researchers' identities.

As well, the ethics application involved safeguards, including the Informed Consent for the co-researchers, stressing their voluntary participation, their right to confidentiality and their right to withdraw at any time during the project without prejudice. I thoroughly read and discussed with the co-researchers the Letter of Purpose of the Research Project, Instructions to the Co-researcher and the Informed Consent. Copies of these documents, once signed, were given to the co-researchers. I also provided to the co-researchers the names and phone numbers of my thesis advisor and program chair, should the co-researchers want further information or clarification. Confidentiality forms were also signed during the *Focusing* workshop (please see Appendix I) to ensure protection and confidentiality of the co-researchers. In fact, having the co-researchers together in the same *Focusing* workshop required exceptional sensitivity, such as asking each co-researcher if his/her names could be shared with the other co-researchers. The researcher taught three different *Focusing* workshops in three different areas of Saskatchewan and this required bringing to bear the same degree of sensitivity and transparency as discussed previously for each site.

As a researcher, I considered ethics when designing the research project (Mertens, 2010) and made a conscious decision to work ethically during the entire project. I worked at honouring the ethical principles of beneficence, respect, justice and minimizing harm. Respecting the ethical principle of beneficence, I maximized the chance of good outcomes by providing an intervention (*Focusing*) that could help the co-researchers with their workplace violence situations. As well, minimizing harm was addressed by having another skilled counsellor available to the co-researchers, at no cost, should something painful or re-traumatizing happen during the Pre-*Focusing* interviews, the *Focusing*

workshop and the Post-*Focusing* interviews. Honouring the ethical principle of respect was achieved by: a) treating the co-researchers equally; b) empowering them to have a voice in the interview; and c) providing transcripts of the interviews plus copies of the findings and discussion to the co-researchers so that they could revise, delete, or add to the transcription documentation. The principle of justice was followed by: a) always asking the co-researchers' permission to start and stop the interview; b) informing the co-researchers of what would be happening at each moment; c) reassuring the co-researchers each time we met that they could withdraw at any time; d) listening carefully to the co-researchers' stories; and e) reflecting back to them what the researcher has heard (for clarity and to avoid minimizing his/her experience of intercollegial workplace violence). As well, I followed my professional Canadian Nurses Association Code of Ethics for Registered Nurses (CNA, 2008), which speaks to nurses creating "moral communities that enable the provision of safe, compassionate, competent and ethical care" (p. 5); all of which is reflected in the quotes, findings, themes and discussion in Chapters Six and Seven. In addition, I followed my own code of conduct by abiding by the Golden and Silver Rules: "Do unto others as you would have others do onto you", and "Do no harm to others as you would have no harm unto you" (McDonald, 2006, p. 3).

Trustworthiness

As a nurse I have experienced, witnessed and intervened in several intercollegial workplace violence situations, and therefore have an understanding of the concepts, behaviour, and patterns of intercollegial workplace violence. This helped me to listen deeply and widely to the co-researchers' experiences. It should be noted that these experiences could also cloud my judgement as a researcher in some ways. I understand

that, as a hermeneutic listener, I cannot be removed from the essence of my own history, or of what has been studied. However, it is this hermeneutic listening and embodied self-interpreting that reflects my passion for this very serious and crucial nursing workplace situation. As a hermeneutic researcher, I have uncovered, unpacked, revealed and illuminated what was hidden in the data (Shinebourne, 2011), while being focused on giving the co-researchers a voice and a safe opportunity to call out to the reader (Todres & Galvin, 2008). Therefore, there is a connection between the reader and the co-researcher, thus facilitating reader empathy toward the co-researcher's suffering (Hamington, 2004).

Chapter Five: Storytelling as Part of the Healing Process

The following three chapters contain the research findings and discussions: a) Chapter Five contains five storyettes; b) Chapter Six contains the Pre- and Post-*Focusing* workshop metaphors; and c) Chapter Seven presents themes and subthemes from the Pre- and Post-*Focusing* workshop interviews.

The five storyettes in this chapter provide the reader with an overall sense of the co-researchers' workplace violence experiences. True to the *Focusing* way, I as a researcher listened closely with the intent of offering unconditional presence to the co-researchers' stories. As Stone, (2004) indicates,

> Listening is soul work. It can help the living find the meaning to go on in the midst of trying circumstances…Without listening, there can be no story. And without stories, we cannot complete the unfinished work of healing. (p. 56)

Storyettes

The nurse who was the golden boy.

A manager took the co-researcher under her wing and treated him very well, although generally she had the reputation of ruling with an iron hand. She seemed to view this co-researcher as 'The Golden Boy' (somebody who is treated differently than others, as the favourite). One day, the co-researcher received a call from a federal department investigating discrimination against a nurse colleague and was questioned about his own experience. The nurse colleague involved had said the manager discriminated against her because she was black. The co-researcher told the federal authorities that he thought he was treated very well and was assigned as many shifts as he wanted. The federal authorities asked the co-researcher, 'The Golden Boy', for documentation regarding his

hours. Shortly after that, the manager called him over to her work area, asked him to enter into a private office and accused him of going to the other nurse's rescue. There was to be a court case, and the manager further accused him of acting against her in the court of law. She threatened him by saying she could make his life miserable. The co-researcher was devastated by this interaction and confused about her information. He did not know what to do after their private conversation. The manager did not want him to take the stand and said that she treated him like 'The Golden Boy' (giving him as many shifts as he wanted). However, this was irrelevant to the court case. He was told if he talked he would pay for it. This frightened him and he thought he should say no more.

A few months later, the federal agency called and again requested documentation regarding his extra shifts, and the lawyer for the nurse claiming discrimination persuaded him very strongly to testify. The co-researcher had initially decided not to say anything, however, the night before court he changed his mind and phoned the lawyer and said that he would tell the court all about his workplace experience, including the threats and the extra shifts. The co-researcher's experience was that everybody was scared of this manager as she ruled through fear. Among the other managers, she was very powerful. The co-researcher explained that the manager lied on the stand but received no discipline or repercussion. The co-researcher then realized that he was on his own and truly alone in this workplace violence situation. Other managers sided with her against the co-researcher and their testimony cast him in a bad light. He told the judge in the courtroom, "You don't know what I will go through and I will pay for it, letting out the truth." The judge said that would not happen; but it did. He felt he was an innocent bystander, not even remotely involved in the discrimination situation.

As the situation proceeded, he felt like the mafia were after him. He could not go to his co-workers because he was afraid his story would get spread around and make things worse for him. It was a long time before he could talk to anybody even though the black nurse was grateful for his courage to speak up in court. He tried to convince himself that it hadn't been that bad – but he felt it was that bad. He decided that, no matter what, they would not get to him, he would get through it. His wife had never seen him in that light – he needed support from her. When he talked about this, he said he felt tension and close to breaking down again. But he didn't think things would get that far. He said he erased and buried stuff now. He had become a professional at dealing with his feelings – but not in a healthy way. He felt that the upper managers publicly singled him out. His life definitely changed from this workplace violence experience and the biggest thing that helped him immediately following this experience was to leave the nursing practice setting.

The nurse who wanted respect and support for her purpose as a nurse.

A newly hired manager for nursing services had not been orientated to the floor, to admissions, to the routines, to the emergency department, to discharges, patient load, or to rounds, all of which was in the job description. She had no knowledge of patient care in this agency. In addition, the new manager did not make herself available to the rest of the nursing staff.

One day, the co-researcher was exceptionally busy with extra admissions but had no beds, while also dealing with a hectic emergency room and caring for a palliative patient. She had several outpatients and one needed to be admitted. There was a team meeting for a patient going back to the community. Significant paper work needed to be

completed for two respite placements going to another agency. By 1:30 p.m., she had had no break, for coffee or lunch. She had been running flat out with nursing responsibilities. When the manager of nursing services arrived at the nursing desk, the co-researcher asked for assistance, specifically, for the discharge functions so she could go to lunch. The co-researcher explained that she had had no breaks. One of the duties in the manager's job description was making sure that nurses had breaks. The manager refused to assist. The co-researcher asked if this was not part of her job description. Was patient care not a priority? She repeated her request to be relieved for a break. The manager said no and walked away.

The co-researcher then went to a higher-level manager about this experience. This manager told her to write it up (which would be on her own time). The senior manager told the co-researcher that her story was very different from that of the manager involved. Nothing more was said or done to resolve the situation. There was no mediation, no problem solving, and no discussion even though the co-researcher was open to any kind of dialogue with the manager. She was interested in knowing what she could have done differently to gain support from the new manager. Everything was swept under the rug and nobody talked about it. The co-researcher shared that she did not feel valued; rather she felt demeaned, frustrated, belittled and insignificant. Trying to make sense of the situation, she concluded that the manager of nursing job description, which included assisting nurses with patient care and relieving nurses' work load, was not being fulfilled. The co-researcher asked the senior manager if the job description had changed, without receiving a satisfactory response. She concluded that management decision-making

included changing the rules frequently without telling the nurses. The co-researcher is committed to providing quality patient care and has tried to stay focused on that.

The nurse who wondered why they would behave this way.

This co-researcher was a primary-care nurse with a medical physician. When the co-researcher was off work due to surgery, another nurse, Licenced Practical Nurse, (LPN) took over her position. When the co-researcher came back to work, the LPN went back to her part-time position but did not give her a report or update her on patients and their procedures. The LPN hid reports and charts and did not tell the co-researcher where they were.

Each time the co-researcher went on sick leave, due to her surgical considerations, the LPN became more abrupt and rude. At one point, the co-researcher approached the LPN and wanted to resolve their tensions. The LPN just looked at her, crossed her arms and demonstrated no interest in resolving their issues or wanting to work with her in a professional manner. So the co-researcher went to the manager to report the situation.

The co-researcher followed all the standard policies and procedures when she felt a co-worker was bullying her. She spoke with her co-worker, then she went to the manager and then she went to human resources. The Human Resources (HR) worker sided with the LPN who demonstrated bullying behaviours and made excuses for her. From then on, the LPN and HR worker came down hard on the co-researcher: phone messages were not given to her; details of work were hidden from her; patients told her that the other nurse was taking her messages and saying, “She does not work here anymore.” The co-researcher took documentation of these issues to her manager and to the HR worker and they said they could not understand what she had written and then lost

her documents seven times. On her way home from a shift, tears would roll down her face. She felt shame from the attention this produced. At a number of meetings with HR and management, she would be hurt, and questioned HR on the way they communicated with her. She could not understand the lack of respect or problem solving that was demonstrated from management and HR people. In fact, she experienced more blame and shame when approaching HR or management for resolution of her workplace violence experiences. The co-researcher concluded that shaming in the nursing profession had gone a long way. She observed that other nurses either put up with it or moved to another position. If she followed policy and pointed out how policy applied to her situation, both HR and her manager “just got mad at her”.

It got to the point that HR people would turn around and walk the other way if they saw her in the hallway. The co-researcher pointed out to management that their behaviour was not appropriate. She always made a point of saying hello and being respectful. She tried to lay out the facts for them and hoped that she did not come across as “smarmy” or as “a smart alec”. She was unsure what had triggered all this bullying and mistreatment. Things escalated over time, and there was no apparent recourse for mediation. Indeed, the manager put her in very stressful situations. Once, the manager assigned her with a physician being investigated for being sexually inappropriate behaviour towards another nurse. The co-researcher was assigned to this physician until they could let him go. She felt this disclosure from the manager was highly inappropriate.

Once the HR person came down to the patient-care area where the co-researcher was working and stood leaning against the doorway. The co-researcher was caring for a very ill, frail woman who could barely talk. The woman was in a wheelchair and she was

whispering as she had just no strength at all. The HR person stood in the patient care doorway making impatient sounds, attempting to attract the co-researcher's attention while she was providing care to this extremely ill and dying patient. Even the patient was aware of the HR person wanting the co-researcher's attention. The HR person wanted to talk about the workplace violence dispute and where the next meeting was going to be held while in the patient area. When the co-researcher went to the meeting with HR, more disrespect was displayed towards her. Because she could not be pushed into agreeing to a more part time position, the HR meeting was abruptly ended. The co-researcher was expected to go back to work as a compassionate person while she experienced tremendous disrespect and bullying.

At her workplace, this co-researcher also took care of the coffee, coffee machine, and the coffee money involved. One day the manager yelled at her saying that she would never return to her original clinical area. Then with the next breath, the manager in a very different tone asked if the co-researcher would still take care of the coffee business in the nursing practice setting.

The nurse who wants to be kind to the patients.

Early in her career, this co-researcher experienced harassment from another nurse while she was providing patient care. She enjoyed, and felt it was part of her job, showing kindness to her patients. She and other nursing staff were 'slapped on their hands' by this senior nurse and told not to touch the patients. These experiences went on for over six years. Anybody being kind to the patients would automatically be verbally and physically attacked by the senior nurse. This nurse was harmful to the patients as well. She would slap them, sometimes across the face, or jab stickpins into the patients

when changing their garments. It was a long bureaucratic process to remove this nurse from the clinical area and to this day some people are still angry with the co-researcher for being a patient advocate and assisting in the dismissal of the nurse, even though she was physically abusive to both the patients and the nursing staff.

Later on, the co-researcher fell and hurt her knee and got a doctor's sick note for the week. The following day the manager phoned her at home. The manager said she had a union representative in the office with a doctor's note stating that she should be back to work that day. The co-researcher had not seen the physician who wrote the note, however, she returned to work. She said she found it interesting that she was able to stand for four hours without a break at work, sore knee and all. The management expectation was for injured nurses to "suck it up" and continue working.

On another occasion, the co-researcher took a stress leave. She handed her manager the note on a Friday but on Monday, the manager phoned to say there would be someone contacting her about a back-to-work program. Furious, the co-researcher pulled the phone off the wall. Over the next days, she saw the manager's car parked across the street. That was extremely stressful; she did not know when the manager would be showing up. After a month, she visited a doctor outside her community and was offered leave for another month but decided not use it. Instead, she started to think strategically: she saved that second sick note 'just in case,' to keep her safe from the manager.

A new RN was hired as nurse coordinator. For about six months this manager checked up on the co-researcher every hour. The co-researcher speculated that they were worried about her taking too many coffee breaks, or perhaps the assistant manager's mother (who was a resident there) had complained about her. Otherwise, the co-

researcher could not figure out why they were checking up on her. This spying bothered her and the co-researcher was constantly on edge. She decided that management wanted to get something on every nursing staff member. In an effort to control her work environment, she moved all the tables in the recreation room into a cubbyhole so that if the managers entered the room they would have to face her. She configured the room so that she could see all who entered.

The co-researcher currently goes to work with the sole idea of getting through the day worrying about her quality of work. Her patient care has deteriorated and she is always on edge due to the ongoing workplace violence experienced in her nursing practice setting. She still cares about the residents but she is unhappy at work. She is always watching her back so she doesn't get called into the office. She used to make the patients laugh and make their day better. She is aware that she is not bubbly like she used to be. She acknowledges that a part of her has died and she can see how that has affected the patients. The patients are more serious, quiet and withdrawn; they look like they feel fear as well.

The nurse who wanted the patients to have high quality care.

One of the things noticed about workplace violence is that you lose your energy to expand or seek out new work. It is more enjoyable and spiritual to be creative and the majority of nurses would rather contribute in this positive manner, but this co-researcher has experienced an accumulation of workplace violence, which culminated in his manager's betrayal. In this co-researcher's facility, there had always been a level of some sort of harassment towards the nurses. Treatment for patients was consistently sabotaged by other healthcare professionals. There was a discrepancy between the stated ideology

about patient care and the actual care provided. When a nurse noted this discrepancy there were serious repercussions. Articulating concerns in this practice setting can be very dangerous and one's livelihood and safety can be compromised easily. This affected the co-researcher's sense of personal power. The co-researcher felt stuck and apathetic but also ashamed because of the "stuckness". Many nurses left the clinical area due to the deterioration of the nursing program, which left the co-researcher feeling alone in the situation.

Patient safety had been greatly compromised to the point where the nursing program at this facility was eventually dismantled. The co-researcher expressed concern regarding possible liability, and had initiated a harassment charge against the manager as well as a mediation process. The mediation process worked better.

Chapter Six: Research Findings and Discussions from the Pre-and Post-*Focusing* Workshop Metaphors

The research project includes Pre-*Focusing* workshop metaphors with themes and Post-*Focusing* workshop metaphors with themes. The information is summarized as the following:

- Table 1 presents the five co-researchers' Pre-*Focusing* and Post-*Focusing* Metaphors (pp. 64-66); and
- Figure 1 presents themes self-interpreted by the researcher from the Pre-*Focusing* and Post-*Focusing* Metaphors (p. 77).

Pre-*Focusing* Workshop Metaphors and Post-*Focusing* Workshop Metaphors

Metaphors represent "a way of seeing something as if it were something else" (Cooperrider & Barrett, 2005, p. 155). Metaphors can be a figure of speech and so may include symbols such as words, mental images, stories or fables. They can also be something that is concrete, "in which a richness of meaning is crystallized" (Combs & Freedman, 1990, p.xiv). The value of metaphors is that they communicate something more than a literal description of an experience. Gendlin (1985) suggests that a metaphor is closely related to an individual's imagination, which represents a large part of his/her world. Metaphors transcend words and give the researcher "an image-picture" (p. 384).

Metaphors were collected for this research project because they gave me- as researcher and reader - a deeper and potentially more extensive understanding of the lived experience (Banonis, 1999) of the co-researchers' workplace violence experiences. By comparing Pre- and Post-*Focusing* metaphoric phase of the interview, it was possible to track how that metaphor changed. The metaphor phase of the interview also invited the

co-researchers to discover their own world-view through a different lens; this helped them self-reflect/self-interpret their experiences, which in itself was therapeutic.

Many mental health professionals have discussed the benefits of listening closely to clients' metaphors (Banonis, 1999; Combs & Freedman, 1990; Cooperrider & Barrett, 1990). The *Focusing* community also uses metaphors and symbols to help the client move (carry) forward in his/her life situation (Gendlin, 2007; Hinterkopf, 1998). Metaphors and symbols coming directly from the client's bodily wisdom (in this case the co-researchers) are doorways from the client's implicit meanings, and experiencing these may assist in an effortless, creative shift of feelings, and promote attitudes towards a more healthy bodily-lived experience (Gendlin, 2003b; Hamington, 2004).

The metaphoric findings (see Table 1, p. 64) from the raw data gathered through the interviews appeared to demonstrate that there is a natural or organic movement within an individual from traumatization to human growth. This was evidenced by skill development and resiliency building. Four co-researchers found it easy to express their workplace violence experience metaphorically and so provided elements of a metaphor when asked to do so by the researcher. One co-researcher, however, had difficulties describing her intercollegial workplace violence using a metaphor. She seemed to remain in the emotional state or pre-metaphor state and expressed feelings such as 'belittling', 'demeaned' and 'insignificant'; all feeling words expressing shame, which will be discussed later (Combs & Freedman, 1990). Perhaps I could have questioned this co-researcher further to draw out a metaphor or metaphoric elements, as emotions are usually the beginning of more explicit symbols (Gendlin, 1985).

Table 1

Shift from the Pre-Focusing Metaphor to the Post-Focusing Metaphor Phase		
Co-Researcher	**Pre-*Focusing* Workshop Metaphor**	**Post-*Focusing* Workshop Metaphor**
Co-researcher 1	"I was scared, threatened and very intimidated and scared for my life and my livelihood. I was impressionable, still and couldn't understand how someone would bring that onto someone else. To try to do what she did to me." "I felt like I was trapped with no real good way out, no matter what I did." "To feel like I couldn't …support my wife and kids and unable to fix this problem or this issue that I had. There was no way that I could, and I felt like a failure, because there was nothing I could do. And it wasn't like me to go cry to mommy or go talk to my wife about it because I shouldn't have to; but I had to in this circumstance."	"Oddly enough the metaphor has lessened. I don't feel at this point in time like as an important part of my life as it did a month ago. So it still holds true, but in the same breath, at this point it's starting to lessen in my mind, and it's no longer as important. The metaphor was very true as how I depict it in my mind and how I remember it. How I recall feeling trapped. I started to think, oh my gosh, that was a horrible experience; if I was to do the exact same interview, it wouldn't affect me as much; it doesn't hold as much power in me anymore; I could stand up in front of a mike, in front of a crowd of people and tell people what I went through. I wouldn't feel as intimidated."
Co-researcher 2	"… made me feel frustrated and it was belittling in the way that it demeaned my purpose as a nurse and the care I was providing…was lack of support when I was feeling overwhelmed by the workload and was met with a lot of confrontation and	"I guess after the (*Focusing*) workshop those are the feelings you usually have after a conflicting encounter or a specific conflicting encounter I had, but when you start to learn new tools or new ways to look inside yourself

	was told that no I wasn't going to get any support and was left to…deal with the workload myself.' "It made me feel very insignificant, like what I was doing wasn't important."	and deal with your feelings; I guess those feelings were in the moment feelings."
Co-researcher 3	"…I think of Aesop's fable. The wind and the sun tried to get the man to remove his coat… the wind barrages and abuses and whips him around and he tightens his coat or cloak around him…the biggest word I come up with is shame." "I have said to the human resources (people) a couple of times, like I'm not sure why you would react that way? And they keep coming back, rather than answer the question; they come back at me with blame or something like I'm costing the agency money…"	"It was just that they were kind of the wind… and they were trying to scare me into shutting up and I have absolutely no problem looking them in the eye and saying that is not acceptable or that is inappropriate."
Co-researcher 4	"It was not safe to be kind to anybody; very traumatising at the time; like a bull that jumps fences harassing all the cows."	"I wasn't as conscientious about my work anymore; I cared less. Since the pre interview, I realize it is still my position and my job to care about people regardless. That has made a difference in my attitude probably… I have learned that it is all up to me; I have to be the one that is comfortable with myself and if I am not comfortable not being kind, I am not being true to myself; so I have to learn to be

		kind to other people so that I can be true to myself. That's who I am, that is my personality." "Most certainly I think it is that session on Sunday (*Focusing* Workshop) helped me to realize to relax a bit more, to be more in tune with myself."
Co-researcher 5	"…being like a three legged fox , that could just drift down the river and land somewhere where it's by itself just so it could recuperate… it's just a kind of place to lick wounds …, I guess my thing, is I'll isolate myself to a degree because I don't want to be a downer… I felt some entrapment."	"I was like a three-legged fox and I was just going down this river; and I did find a place and I think I even had little pups around me or something. The pups (one or two) were quiet. I just needed to be alone; only warm sun and time would be good; it was just like I needed the space, just to recuperate."

Table 1. Verbatim quotes reflecting workplace violence metaphors from the five co-researchers as provided during Pre- and Post-*Focusing* Workshop interviews.

Pre-*Focusing* Workshop Metaphor (Pre-FM) Thematizing

For the purposes of this metaphoric phase of the thesis project, a theme is any word or phrase shared by two or more co-researchers. As I practiced *Focusing* (as part of my self-reflection and self-interpreting process) on the meaning of the Pre-FMs, five themes emerged: (1) shame; (2) fear of being unsafe; (3) abuse; (4) trapped/entrapment; and (5) vulnerability.

1. **Shame**: Four co-researchers spoke to the theme of shame. Shame refers to when one has a feeling of being flawed, unworthy, unacceptable and not belonging (Bradberry & Greaves, 2005; Brown, 2007). Bradberry and Greaves suggested that shame is one of the five core feelings for humans. Brown (2007) stated: "…I often refer to shame as the fear of disconnection – the fear of being perceived as flawed and unworthy of acceptance or belonging" (p. xxv). As I interpreted the raw data, I suggested that all these fears have been experienced by the co-researchers due to workplace violence.

The co-researchers used feeling words such as 'felt like a failure', 'belittled and demeaned'. There was a tone of ridicule and rejection, and a feeling of being diminished in these Pre-*Focusing* workshop phrases – all of which belong to the experience of shame. One co-researcher declared, "The biggest word I come up with is shame". Another co-researcher indicated in the Post-FM interview that, "I'll isolate myself to a degree because I don't want to be a downer". This statement suggests embarrassment which is another word for shame (Brown, 2007) and people tend to hide when they feel shame. Another co-researcher stated that he should not have to go to his wife for support, suggesting that he was embarrassed that he had to. He has learned from our culture that it

is not right for a man to go to his spouse for support so needing and going for such support causes shame. Brown (2007) suggests that people will change their thinking, behaviours and feelings to avoid being shamed.

2. **Fear of Being Unsafe**: The co-researchers shared the following words, "scared for my life and my livelihood" and "It was not safe to be kind to anybody". The co-researcher who related the fox metaphor, imagined that the fox "just drift down the river and land somewhere where it's by itself just so it could recuperate". This co-researcher needed to be somewhere safe and away from others to heal.

3. **Abuse**: For example, in a co-researcher's wind metaphor: "...the wind barrages and abuses and whips me around... and they (managers) come back at me with blame or something like I'm costing the agency money…". Clearly, this co-researcher is feeling very abused and mistreated. For the co-researcher who described his/her abuse as "...a bull that jumps fences harassing all the cows", the trauma in the workplace is experienced as a persistent masculine and patriarchal energy that harasses the nurses.

4. **Trapped or Entrapment**: Examples from the co-researchers are, "I felt like I was trapped with no real good way out, no matter what I did..." and "…I felt some entrapment". In *Focusing* language, these would be considered 'Dead Ends' (Gendlin, 1996). Gendlin suggests that dead ends can be experienced in two different ways: as an unchanging feeling pattern, or that something should or should not be done about his/her life situation. In either case, the individual is unable to do anything to make a change.

5. **Vulnerability:** The co-researchers spoke of vulnerability as:

a) isolating themselves: "…. I'll isolate myself to a degree because I don't want to be a downer…"; or "… like a three-legged fox that could just drift down

the river and land somewhere where it's by itself just so it could recuperate… it's just a kind of place to lick wounds…";

b) not wanting to go to one's wife or family member for support: "… it wasn't like me to go cry to mommy or go talk to my wife about it because I shouldn't have to …"; or

c) not wanting to discuss issues with human resources: "…. rather than answer them (the co-researcher's questions), they come back at me with blame or something like I'm costing the agency money…".

When I looked at these metaphor phrases at an embodied self-interpreting level, I understood that the co-researchers were in very vulnerable places. As Conti-O'Hare (2002), a Registered Nurse, states, "All too often, however, health professionals are reluctant to reveal themselves because of the potential for vulnerability, created largely by an orientation toward perfection and flawless performance" (p. 2). From my experience and observation, nurses do strive to be flawless and independent in their own problem solving.

Again, when I looked at the data from a deep level of self-reflection and self-interpretation, it could be seen that the co-researchers were trying to process the trauma they experienced, or were attempting to reason with the person exhibiting abusive behaviour. For example, one co-researcher reported trying to reason with a human resource's representative: "…like I'm not sure why you would…say that or why you would react that way?" Another, trying to understand the manager's behaviour stated: "…I still couldn't understand how someone would bring that onto someone else. To try

to do what she did to me." On analysis of their self-interpretations, it seemed to me that the co-researchers were wounded nurses (Conti-O'Hare, 2002).

In the metaphor phase of the co-researchers' interviews, they shared their experiences through their metaphors. As Nouwen states, "Words such as 'alienation', 'separation', 'isolation' and loneliness' have been used to name our wounded condition" (1979, p. 89). All of these universal human conditions showed up in the metaphors one way or another.

Post-*Focusing* Workshop Metaphor Findings (Post-FM)

The Post-*Focusing* metaphors gathered during the Post-*Focusing* Workshop interviews demonstrated transformation and transcendence from shame, fear of being unsafe, abuse, being trapped and vulnerability. The transformation fit the themes of: 1) healing process emerging; 2) liberated feelings; 3) establishing firm boundaries; 4) being true to myself (Self); and 5) fresh, creative, spiritual and hopeful way of being.

In metaphoric language, "Transformation can be likened to the odyssey of the butterfly, whose basic essence remains constant during its transfiguration from caterpillar to isolative cocoon and finally to its emergence as a beautifully coloured air-borne creature" (Conti-O'Hare, 2002, p. 87). The co-researchers experienced transformation as they struggled to become new beings through something traumatic and possibly dangerous. Aspects of transformations become evident in the changed language of the metaphor during the Post-*Focusing* metaphor phase of the interview (Table 1, p. 64). In the context of this research project, I suggest that the wounded co-researchers discovered inner strengths, resiliency, self-efficacy and a larger Self (Egnew, 2005). There were both clear and subtle differences between the Pre-*Focusing* and the Post-*Focusing* metaphors

and in the metaphor language used by each co-researchers (see Table 1, p. 64), as illustrated in the following section.

1. **Healing Process Emerging:** The first co-researcher stated, "…I don't feel at this point in time like it (workplace violence experience) is as an important part of my life as it did a month ago" (less than one month after the *Focusing* workshop). This suggests that there was a significant shift. This is the co-researcher whose Pre-*Focusing* metaphor was "being scared for my life and my livelihood…" and "…I felt like I was trapped with no real good way out, no matter what I did…". Subsequent to the *Focusing* workshop experience, this co-researcher demonstrated transcendence from his intercollegial workplace violence when he stated, "I could stand up in front of a mike, in front of a crowd of people and tell people what I went through. I wouldn't feel as intimidated". This indicated that there was a healing process emerging. Egnew (2005) in his qualitative study operationally defines healing and concludes that "Healing (is) defined as the personal experience of the transcendence of suffering" (p. 255). Healing is associated with spirituality, wholeness and a narrative process, all of which are reflected in this research project.

2. **Liberated Feelings:** Another co-researcher stated, "…after the (*Focusing*) workshop… you start to learn new tools or new ways to look inside yourself and deal with your feelings". These words demonstrated moving forward from a feeling of being 'frustrated', 'belittled', 'demeaned', and 'very insignificant' (words from the co-researcher's Pre-*Focusing* metaphor interview), to learning new ways of dealing with such feelings. This nurse liberated her feelings from frustration to acceptance and from belittled to feeling empowered. She looked into her own wound (Nouwen, 1979) and

transformed and transcended her feelings through self-reflection (as part of the *Focusing* experience), thereby learning new tools and new ways of being (Conti-O'Hare, 2002). The *Focusing* workshop experience helped her not go to a 'Dead End' with her feelings and not let the trauma "get a hold of her" (Gendlin, 1996, p. 93). At this Post-*Focusing* phase, she took a friendly attitude towards her feelings. This is the foundation of transformation. Rather than getting stuck with her feelings, she found a way out and then transformed her feelings into new ways of being.

3. <u>Establishing Firm Boundaries</u>: One co-researcher stated, "…I have absolutely no problem looking them (managers and human resource people) in the eye and saying that is not acceptable or that is inappropriate." This co-researcher moved forward from her experience of 'shame' as suggested by her Pre-Workshop metaphor ("the wind barrages and abuses and whips me around") to establishing firm boundaries between her and management. These boundaries grew from the core issues of trust and feelings of suffering (Whitfield, 1993). The co-researcher could not trust management in her nursing practice setting due to being shamed and blamed; thus she experienced suffering. Whitfield describes core issues as "…a conflict, concern or potential problem, whether conscious or unconscious, that is incomplete for us or needs action or change" (1993, p. 139). In this co-researcher's Post-*Focusing* interview, she was able to work through her core issues of experiencing shame and distrust by speaking her truth. Whitfield indicates that "Knowing what is appropriate…" (1993, p.143) is demonstrating recovery from trauma.

4. <u>Be True to Myself (Self)</u>: A co-researcher stated "I have learned that it is all up to me; I have to be the one that is comfortable with myself and if I am not comfortable

not being kind, I am not being true to myself; so I have to learn to be kind to other people so that I can be true to myself (Self). That's who I am; that is my personality." She also stated that the *Focusing* workshop "helped me to realize to relax a bit more, to be more in tune with myself." As a researcher, I interpreted this co-researcher as returning to her authentic Self, evolving to a larger Self and establishing Self-boundaries (Whitfield, 1993). Wolin and Wolin (1993) stated: "Morality aims to repair an injured self and to improve the world as well" (p.5). In her workplace situation, the co-researcher wants to improve the well-being of the patients by being kind to them because that is being her authentic Self. From a *Focusing* bodily felt sense perspective, this co-researcher made a shift from not being kind enough, to accepting herself as an authentic kind human being and therefore being true to her Self. As Gendlin stated, "In such a step or shift one senses oneself differently" (1996, p. 21).

5. <u>Fresh, Creative, Spiritual and Hopeful Way of Being</u>: A co-researcher stated, "I was like a three-legged fox and I was just going down this river; and I did find a place and I think I even had little pups around me or something. The pups (one or two) were quiet." This demonstrated a significant and powerful bodily shift from "…being like a three-legged fox...it's just a kind of place to lick wounds" as stated in the Pre-*Focusing* metaphor phase of the interview to talking of having quiet pups. This co-researcher was acknowledging and recognizing the seriousness of her wound and therefore engaging in a transformative and transcending process (Conti-O'Hare, 2002). As the hermeneutic listener, I suggest that the *Focusing* workshop assisted this co-researcher in listening to her wounded parts and self-reflecting on her workplace intercollegial violence experience. In this co-researcher's metaphoric situation, she gave birth to something new

– fox pups. She carried forward her lived workplace violence into a fresh, creative, spiritual and hopeful way of being. One of the purposes of *Focusing* is to listen to one's bodily sensations, feelings, and to meanings from one's body wisdom in order to carry/move forward in one's life (Campbell & McMahon, 1997; Gendlin, 1964a, 1996, 2007; Hinterkopf, 1998; McMahon, 1993).

Pre- and Post-*Focusing* Metaphor Findings Summary

This section related the findings from a three part self-reflecting process for the co-researchers: 1) during the Pre-*Focusing* metaphor phase each co-researcher shared his/her metaphor and then continued with a lengthy interview. The power of storytelling with me listening and reflecting his/her story was evident in the Pre-FM interview. This is a *Focusing* skill (Gendlin, 2007; Madison, 2001), and a healing art in and of itself (Stone, 2004). 2) Each then experienced a *Focusing* workshop, which is an in-depth self-reflection process. The power of listening to oneself was emphasized during the *Focusing* workshop. And finally, 3) each experienced self-reflection during the Post-*Focusing* metaphor phase and interview, and the power of listening to a transformative and transcending Post-metaphor interview formed the final self-reflecting process. One of the benefits of *Focusing* is self-reflecting and listening to oneself, which will initiate a transformation, or, from a *Focusing* perspective, will promote a moving/carrying forward process.

Shaming others is a method of oppression and a means of controlling behaviour. Brown (2007) states,

> ...the power of shame as a social tool that's often used to keep us quiet. Nothing silences us more effectively than shame...shame is more than insensitive

> communicating or a self-esteem issue; it is a basic human experience that is becoming an increasingly divisive and destructive part of our culture. (p. xxiii)

Further, Barrett (1996) states that, "In our culture which frequently denies or is embarrassed by suffering, the possibility of suffering may have a healing or transforming function…" (p. ii). In her article, *Faithful Suffering*, she states "…Suffering holds us tightly until we begin to know ourselves deeply…holds us until we find a new, more life-giving relationship with our God. She holds us even longer, until at last we find a new way to be in relationship with the world" (Barrett, 1996, p. 6).

Metaphors present a different language than the standard interview. Much like poetry, metaphors are aesthetic in nature. That is they deal with beauty and emotions and are open to interpretation. Metaphors arrive from an embodied expression (Todres & Galvin, 2008) as one of Heidegger's 'existentials' (embodiment, spatiality and temporality). Further, metaphors are an important part of "Gendlin's philosophy of the body and his practice of '*Focusing*'" (Todres & Galvin, 2008, p. 568), which assisted the co-researchers in finding symbols that carry (move) forward his/her lived meaningful experience. Metaphors are personal and become interpersonal as they call out to others. The metaphors expressed by the co-researchers seemed like calls for ethical support and taken together, provide a strong, vivid, vibrating description of what it is like to work in the healthcare sector and suffer on-going intercollegial workplace violence. Metaphors came from deep within each co-researcher; metaphors are personal and become interpersonal as they called out to others.

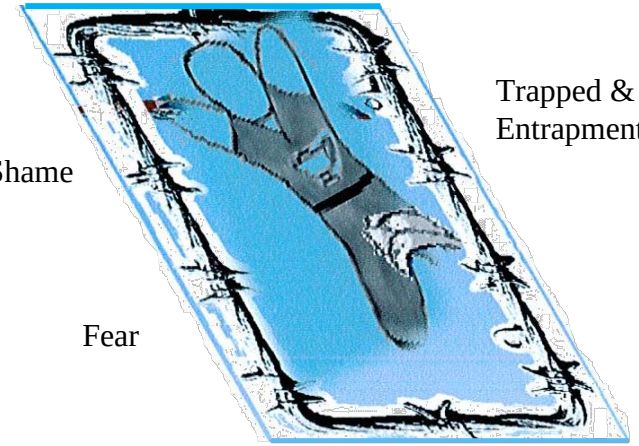
The Post-*Focusing* metaphors show a shift from Pre-*Focusing* metaphors: places of shame, fear of being unsafe, experiencing abuse, feeling entrapment or being trapped

and vulnerability to liberated feelings, to self-reflecting/moving forward processes, to being true to Self, to hopeful ways of being and to establishing firm boundaries. These themes are captured in Figure 1: Metaphoric Phase Themes on page 77**.**

Figure 1. **Metaphor Phase Themes**

Pre-Focusing Workshop Metaphors

Vulnerability



Trapped & Entrapment

Shame

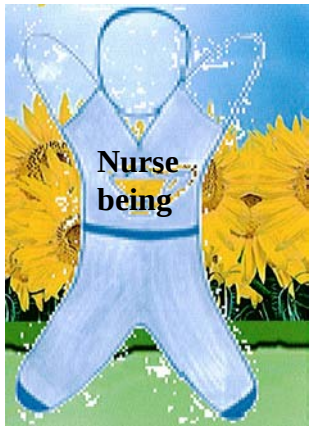
Fear

Abuse

Post-Focusing Workshop Metaphors

Healing Process Emerging

Establishing Firm Boundaries



Liberated Feelings

Being True to Myself

Fresh, creative, spiritual, hopeful way of being

Chapter 7: Themes from the Pre- and Post-*Focusing* Workshop Interviews

This chapter will present Pre-*Focusing* workshop interview themes and sub-themes as well as Post-*Focusing* workshop interview themes and sub-themes. The interviews were interpreted in two parts: the metaphors were explored in Chapter Six with the remaining material from the interviews analyzed in this chapter in the following manner:

- Figure 2 contains the five themes presented from the Pre-*Focusing* Workshop Interviews and Post- *Focusing* Workshop Interviews (p. 80)**;**
- Each theme will be described within the context of the research regarding intercollegial workplace violence in the nursing practice settings;
- Each theme has sub-themes that will be described by the researcher, followed by quotes from the Pre-*Focusing* Workshop Interviews and Post-*Focusing* Workshop Interviews;
- The researcher will self-interpret meanings of the quotes, drawing support from the related literature; and
- From the Pre-*Focusing* and Post-*Focusing* interviews with the co-researchers, five themes emerge and each theme has three or more sub-themes.-

These themes and sub-themes were developed through a specific process. If three or more co-researchers mentioned similar experiences, these were considered high-frequency experiences and so became a theme. Similarly, if three or more co-researchers mentioned similar experiences that could be part of an established theme, then these experiences became the sub-themes for the theme being discussed. Further, if a significant phrase was

mentioned by only one or two co-researchers, then this phrase was also presented as a theme or sub-theme.

The resulting themes and sub-themes reflect the co-researchers' experience before the *Focusing* workshop and their experience after the workshop. Effort by the researcher has been made to draw attention to the extent of any changes and how the experience of workplace violence may have shifted in nature. The themes and sub-themes were:

Workplace Violence:

Sub-themes: a) Power issues, b) Shaming behaviours and c) Safety and boundaries

Poor Healthcare:

Sub-themes: a) Decision making, b) Mental health of the nurse and c) Concern for the patient

Resiliency:

Sub-themes: a) Insight, wisdom and awareness, b) Creativity and humour, c) Healthy relationships and d) Self-efficacy

Embodied spirituality:

Sub-themes: a) Dead ends, b) Loss of self and grieving and c) Shame and suffering

Embodied caring:

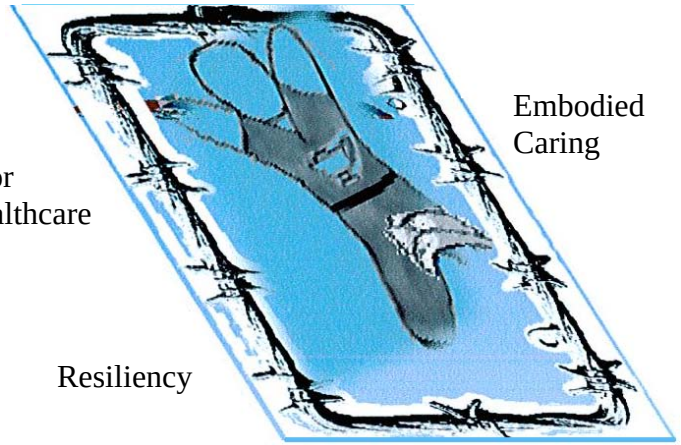
Sub-themes: a) Conflict resolution, b) Embodied caring for self and others and c) Safety for self and others

These themes and sub-themes are reflected in Figure 2 (p. 80).

Figure 2 **Interview Phase Themes**

Pre-Focusing Workshop Interview Themes

Workplace Violence



Embodied Caring

Poor Healthcare

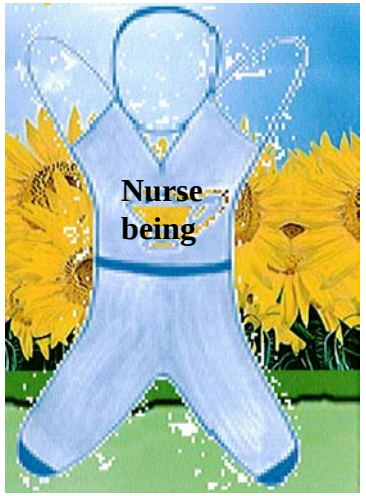
Resiliency

Embodied Spirituality

Post-Focusing Workshop Interview Themes

Workplace Violence

Poor Healthcare



Embodied Caring

Resiliency

Embodied Spirituality

Theme: 1. Workplace Violence

Workplace Violence, in the context of this thesis, is defined as: a) "sustained exposure to violence in the workplace, including aggression, abuse and bullying" (RNAO, 2009, p. 20); b) the experience of intercollegial hostility (Bartholomew, 2006); c) incivility where one co-worker disregards another and the other is affected (Pearson & Porath, 2009); and d) shaming behaviours such as: disrespect, non-constructive criticism, scape-goating, intimidation, threats, gossiping, nit-picking, silent treatment, gesturing and denial of basic human needs (CNA, 2010). The sub-themes under the Work Place Violence theme were 'Power Issues', 'Shaming Behaviours' and 'Safety and Boundaries'.

Workplace violence: Power issues.

Power issues are described, within the context of this research project, as different agendas and expectations between healthcare professionals and/or management and nursing staff, where the conflict is between someone of high status or authority and someone who has lower status, authority or power. Power issues are described explicitly by Pearson and Porath (2009) as "Offenders and targets possess(ing) differing amounts of power and (who) use this power differently" (p. 15). These authors also suggest that approximately sixty-percent of power plays come from the offender who has a higher job status than the target individual.

Pre*-Focusing *workshop interview data.

What the co-researchers had to say during the Pre-*Focusing* Workshop interviews resonated with Pearson and Porath's (2009) view of power issues. One co-researcher mentioned how everybody felt unsafe in the nursing practice setting because of the

manager's behaviour. The co-researcher stated: "...She (the manager) ruled with an iron hand. Nobody would stand up to her…Everybody was scared of her. She was a very powerful lady, she used a stick; she ran a tight ship but used fear (to manage)..."

Another co-researcher experienced layered intercollegial violence - one layer from her co-worker, another layer from her manager, and a third layer from Human Resources. This co-researcher stated:

> …when I go to work... stuff is hidden on me, phone messages aren't relayed...A patient just about fell over when she saw me in the clinic...said, 'I phoned your extension and someone answered it and told me you didn't work here anymore'…and a co-worker (a nurse colleague) told me that she (another colleague) was taking messages on my phone and not passing them along...

It is notable in this quote that this patient was affected by what was happening to this co-researcher, which supports the notion that workplace violence can extend to patients as well.

The co-researcher who provided the above quote mentioned that she did discuss the events with her manager and the manager stated, 'Well your documentation is too mixed up. I'm confused by it'. Here is a situation where the co-researcher experienced workplace violence from her colleague and the manager was not willing to deal with her issue. Further, the co-researcher stated, "…my employer (Human Resource people) has lost seven sets of my documentation." Losing seven sets of documentation suggests lack of support for this co-researcher and lack of interest in resolving this issue. Other authors have recognized the above as intercollegial violence. For example, Bartholomew (2006)

suggests that the above described type of intercollegial violence is covert sabotaging, fabricating and refusal to help/support a colleague.

In another example of workplace violence - power issues - a third co-researcher experienced oppression, favouritism and punishment (classic power issues). This third co-researcher said:

> ...the manager likes to sneak up on us and come in and spy on us... she refused to fill the shifts. She (the manager) said, 'I can do what I want with them'; if she decides she likes you, she will fill them out and if she doesn't, she doesn't (fill the shift out)...

Post*-Focusing *workshop interview data.

Discussions on workplace violence power issues changed after the *Focusing* workshop. During the Post-*Focusing* workshop interviews, three co-researchers had transformed their experience into having less suffering and less emotional intensity around the experience of workplace violence. One co-researcher moved from feeling intense fear during the Pre-*Focusing* (he mentioned being surprised by how affected he was when sharing his workplace violence experiences) to demonstrating emotional intelligence (Bradberry & Greaves, 2003). During the Post-*Focusing* interview he articulated awareness of what nurses do to each other, along with social competence – how workplace violence affects nurses collectively and socially. He was able to see the bigger picture of how intercollegial violence affects everyone involved. Having this new perspective seemed to reduce his intense feelings of fear, which is a healthy and a hopeful change. Again, seeing the bigger picture, he also suggested that violence caused more

violence among nurses. This co-researcher articulated his change by describing the bigger picture:

> ...It's that old saying; and I didn't know what it meant when I went through nursing school, but 'some nurses eat their young' and she (manager) was one of them and this affected a lot of people. And I know there are still hurt people out there. People are hurting because of her, because of the way the violence occurs...

This co-researcher is considering how other nurses, nursing in general, and workplace violence hurts people; not solely focusing on his own personal experience.

Another example of change after the *Focusing* workshop occurred with a second co-researcher. This co-researcher found her own dignity in the midst of the personal, professional, and organizational hostility, injustice and oppression. During the Post-*Focusing* interview, she demonstrated that she was now listening to the spirit in her body. During the Pre-*Focusing* interview she said she felt shamed and abused but after the *Focusing* workshop she said that she knew that she was a good nurse and she did not need to justify that. For example during the Post-*Focusing* interview she said: "...I am a very good worker and I am a very good nurse and I did tons of extracurricular things...". For this co-researcher, when a manager did mistreat her, she responded by not getting emotional. She chose not to respond to the violent communication. For example she mentioned how the manager "…. rattles at me, and you can't do this and you can't do that, I'm going to move you here and you are still going to look after the coffee machine, right? It (the workplace violence from the manager) didn't even justify a response...".

A third co-researcher also showed a change in how she responded to the workplace violence power issues. She now appeared committed and less anxious about

reporting concerns to the manager. This co-researcher mentioned, during the Post-*Focusing* interview, that other colleagues had told her that they experienced workplace violence ("hits") from the manager after she (this co-researcher) reported workplace issues. As the co-researcher described: "The girls (colleagues) say to me (the co-researcher), 'as soon as you say anything to the manager; she comes back and hits all of us (psychologically), so why do you say anything?" However, the co-researcher insisted on the need to report workplace issues to the manager. The co-researcher told her colleagues: "... well, if there is no record of anything going on (concerns with the practice setting); if you don't say anything then there is no record of anything happening...". Clearly the co-researcher is now comfortable in modelling ethical and professional behaviour for the benefit of all.

As the researcher, I listened deeply to the above statements by the co-researcher and heard a voice of morality and justice. This co-researcher wanted something stated for the record, no matter what the consequences and no matter what the peer pressure.

Conti-O'Hare (2002) discusses the process of achieving Self-transcendence, which involves personal boundaries being open and extending past the accepted constricting views into the environment (workplace) where activities (reporting issues to the manager), practices (not responding to the fear of the manager) and purposes change for the better. This seems to resonate with this co-researcher's commitment to report workplace issues to the manager no matter what.

Workplace violence: Shaming behaviours.

Shaming behaviours, as described in the literature review, are bullying, harassing, mobbing, gossiping and cliques. Such shaming behaviours trigger a felt shamed

experience in the victim. Brown's (2007) book on shame states "…the power of shame as a social tool that's often used to keep us quiet. Nothing silences us more effectively than shame" (p. xxiii). During the Pre-*Focusing* Workshop interview the co-researchers shared the following about felt shamed experiences that were triggered from shaming behaviour thrust upon them from other colleagues (RNAO, 2009; Riehl, 2009).

Pre*-Focusing *workshop interview data.

For this first co-researcher, crying was believed to be shameful, as he stated: "…cause I had to cry on my wife's shoulder. I had to, ah, cower when I walked down the hallways, professionally, as a good nurse. I can't do that anymore."

For a second co-researcher, shaming was clearly initiated by the manager, and shaming behaviours resulted in silence from the nurses. She said:

> ...and I think sometimes being female, being a nurse, being Catholic, you know, I think in our profession shaming has gone a long way. And people have either quit or moved to a different area or kind of put up and shut up because they know that it's usually someone in a higher authority position will ridicule them or mock them and that has happened to me.

The power of shame through active and deliberate silence (refusing to respond to another colleague) caused this co-researcher to experience shame. She explained: "Everybody knew what was going on. She then printed something off, whipped it out of the printer and walked away from me and didn't give me a response."

All three of the above co-researchers experienced shame and wished they could be silent by not crying; or be out of sight in order to move from the hostile situation; both are painful solutions to an unbearable experience.

Post*-Focusing *workshop interview data.

During the Post-*Focusing* interviews, changes in the co-researchers were noticed. This first co-researcher acknowledged how horrific his workplace violence experience had been, but stated during the Post-*Focusing* interview that the experience did not affect him as much. There was a shift in the intensity of the workplace violence experience. As he explained:

> ... A month ago, when I talked about it, it kind of all boiled up again. Or I started to think, oh my gosh, that was a horrible experience.... I didn't relive it, but ... it took me my surprise that really ... And then I started talking to the researcher about it and I was like, whoa, this is still affecting me... now to present day, if I was to do the exact same interview with the researcher it wouldn't affect me as much...

A second co-researcher had the opportunity to work in another practice setting; however, she chose not to put herself in a position of being shamed and mistreated again. Self preservation kicked in. She said:

> ...I don't think I could go through something like this again and these people have demeaned and belittle and defamed me and made new rules and regulations just for me and I did work at a (another) job…but I did that for a month and I just thought I don't think I could ever afford to be put down or run down or so I resigned and I just said, I'm not the person you need…The owners of the company phoned and said, 'would you please reconsider, we really think highly of you…please call me'; and I just couldn't…I do have the potential, but I just won't ever put myself in that situation again…

A third co-researcher stated in her Pre-Metaphor phase that she felt belittled, demeaned and insignificant all of which are from shaming language. In the Post-*Focusing* workshop interview, she self-interpreted her feelings and let them go so that she could move forward. This co-researcher explained:

> ...I think in recognizing certain feelings or certain emotions, then in order to let go of those, you have to recognize that they are there and acknowledge them and …and (make) a choice to let go of them and move forward move through it...

In their various experiences of shame, two co-researchers talked about feeling demeaned and belittled as well as feeling defamed and insignificant. However, one co-researcher self-reflected and recognized her shameful feelings and chose to let them go and move forward. This could be an outcome from a *Focusing* experience (Gendlin, 2007; Hinterkopf, 1998; McMahon, 1993). The other co-researcher chose to self-preserve and not repeat a similar shameful experience.

What is important from the above statements is that the experience of shame was triggered from within the culture, in this case the healthcare workplace culture. Shaming behaviours are meant to send messages and expectations in order to control another's behaviour. In order to prevent the experience of shame we (the co-researchers) need to "change our behaviours, thinking and feelings to avoid feeling shame. In the process, we change who we were and, in many instances, who we are now" (Brown, 2007, p. xxiv).

Workplace violence: Safety and boundaries.

Safety and boundaries are very important for both the healthcare providers and the patients. When psychological boundaries are crossed or broken, safety for both healthcare providers and patients becomes a serious issue. As Pearson and Porath (2009) state,

"…incivility within teams... decreases members' sense of so-called psychological safety, the feeling that the team environment is a safe place to take risks" (p. 81). When team members are affected by workplace violence of any kind, the team players will be cautious and less willing to seek out feedback. They will stop asking for support, stop reporting errors and stop sharing information around potential mistakes. As a result, patients' lives are put at risk.

Pre*-Focusing *workshop interview data.

In one particular case related to workplace safety and boundaries, a co-researcher took a tremendous risk. He risked his well-being, safety and livelihood when he complied with a request to testify in court regarding workplace violence. There was a tremendous cost for him following the court case as he was marginalized and ostracized by his workplace colleagues for supporting a fellow worker. Subsequently, he established and maintained a boundary by walking away from the organization because of lack of trust in management. He said: "...I told the judge that I am going to say some things but will pay for it. The judge said this will not happen; but it did. I felt like it was like the mafia. I walked away; I felt alone, trust is zilch! ...".

A second co-researcher needed to set boundaries with another colleague, which again resulted in repercussions from her colleague and the manager. Unfortunately, a patient was involved in some of this workplace hostility. This co-researcher said:

> ...and I remember twice in particular I said '…why are you talking to me like this?' and also I said '… just stop right there. I don't appreciate the way you're speaking to me, and please don't speak to me like that again, and I'm leaving this

> conversation and you can carry on when you're, able to speak to me as an adult.'
>
> ...I was in a room with a patient and her husband doing a bit of an assessment...

This third co-researcher created boundaries for herself and for the patients by moving them into a safer area in order to control situations where she felt unsafe. She would meet management in the hallway before they could come down to the patient-care area. This co-researcher said:

> …so it got to the place where I closed our dining room doors and moved all the tables into a little corner so I could work with them (the patients) without them spying on me and then I got smart and going down the hallway and meeting them coming down and they would say, oh I can't remember what I was coming down for…

When boundaries are violated, individuals struggle to define themselves and to maintain a healthy well-being of Self (Whitfield, 1993).

Post*-Focusing *workshop interview data.

During the Post-*Focusing* interview, the following co-researchers showed a shift from needing to set boundaries and protect themselves and patients to expressing concern about organizational management and policies, and in this way transcending their suffering. During the Post-*Focusing* interview, these co-researchers were looking at the bigger picture and the well-being of nurses generally.

The first co-researcher came from a spiritual 'True Self' as he spoke of the dark and the light sides of his manager and he recognized the reasons for her shaming and abusive behaviours. As well, he recognized that other nurses who worked with her needed healing from their own experience of workplace violence. This could be viewed

as transcending one's original fear, pain and suffering, and moving forward beyond one's ordinary experience (McMahon, 1993; Pranke, 2005). This first co-researcher said:

> ...But there are some people that, maybe in a different environment they will function better, but there … nursing managers that aren't good. The one that I had to deal with, the one that was quite abusive to me. She ran an unbelievable unit and was very good at that; but her people skills at running nurses, at moving nurses or whatever, were poor…

A second co-researcher maintained clear strong boundaries with management and understood that management policies were only reliable in certain circumstances – useful tools for management; such policies were negated or not enforced when referred to by the co-researcher. This co-researcher said:

> ...they were just trying to scare me into shutting up and I have absolutely no problem looking them in the eye and saying that is not acceptable or that is inappropriate. At one time I said 'there was an issue' and I said, 'well that is not according to policy' and the Provincial Nursing Manager said, well that isn't in our policy, that's not part of our policy so I gave her the book and showed her where it was and so she just took it with a huff and just slammed the book down...

A third co-researcher and her colleague believed that the manager was entering the healthcare agency unannounced, checking patients' rooms and checking up on staff, which led the co-researcher to report the incident, which created a boundary and improved workplace safety for everyone.

> …the residents have verbalized somebody has been in my room, 'what are they doing in my room at night' and I said there is only the two of us. 'Well it wasn't

> you two, it was somebody else'. And I am saying okay, if they are coming in and disturbing the residents, I want to argue that the residents need protecting as well. It is not just me or the staff, but the residents are also starting to become woken up in their sleep and scared and it has really been interesting. I did get hauled in because I reported that one incident and she wanted to know why I would think that there was somebody in the room. I said because the resident knew me and the other colleague, and she said it wasn't us and there was somebody in the room. I said I have the door shut a certain way and when I went back to make rounds it wasn't shut the same way so I knew that somebody was in the building...

Whitfield (1993) in his book, *Boundaries and Relationships: Knowing, Protecting and Enjoying the Self,* suggests that people who are aware and keep healthy boundaries will know which people are toxic and not safe to be around. They will know when they have been abused and mistreated. The co-researchers discussed above showed during the Post-Workshop Interview that they had broken away from unnecessary suffering and pain. They have demonstrated learning, growth and healing. They showed their authentic Self.

Workplace violence theme summary.

Conti-O'Hare, in her book, *The Nurse as Wounded Healer: From Trauma to Transcendence* (2002), succinctly summarized this theme:

> Although wounding and trauma result from an unfortunate happening, the latter tends to connote a more intense and serious outcome…both can be reduced to physical, psychological, emotional, social, or spiritual components. Whatever the

> source, the injury can profoundly affect the individual and have long-term repercussions." (p.51)

As the findings from the co-researchers' experiences unfolded, I noticed that their human components (spiritual, emotional, social, psychological, and physical) were deeply affected by the intercollegial violence both in a traumatic/wounding way and in a transformative/transcendent moving-forward way.

Theme 2: Poor Healthcare

The Poor Healthcare theme refers to patients not receiving safe, competent, compassionate ethical care due to intercollegial workplace violence (CNA, 2008). Pearson and Porath (2009) stated that "When they (co-workers) were treated uncivilly, people felt so bad that they did what they could to punish the wrongdoer" (p. 52). According to these researchers, such incivility (workplace violence) in turn harms performance (quality patient care) causing workers to stop caring and creating poor job satisfaction, thus allowing anger to creep into the workplace. The sub-themes for Poor Healthcare were decision-making, mental health of the nurse, and concern for the patient.

Poor healthcare: Decision making.

Within the context of this research project, 'decision making' refers to how decisions made by managers affect the healthcare professionals and therefore patient care. Pearson and Porath (2009) suggested the Golden Rule works like this – the way managers interact with staff determines the way staff members interact with the patient. This Golden Rule has similar meanings to the Christian Golden Rule, "Do unto others as you would have others do unto you" and I would add a Silver Rule, "Do no harm to others as you would have others do no harm to you" (McDonald, 2006, p. 3).

Pre*-Focusing *workshop interview data.

Only two quotes from co-researchers fully illustrate the sub-theme; however, they clearly demonstrate the issue of poor healthcare as a result of workplace violence and are directly related to decision-making. Three co-researchers (two directly and one indirectly) reported that managers often made decisions without sharing those decisions with the healthcare workers involved in their implementation or who would be affected in other ways. The first co-researcher indicated that no clear management decision about the garbage was communicated to the nursing staff, which caused the staff unnecessary stress and created conflict between different types of healthcare providers. The first co-researcher said:

> ...so like if you had soiled stuff you put it in the garbage, housekeepers would come and pick it up once a day or twice a day; had for years and years and years. One day they didn't want to do that anymore, so we were all getting in trouble for leaving the garbage behind in the garbage cans...

Another co-researcher shared how both staff and patients were placed at risk due to management decisions not being passed onto the healthcare workers. The second co-researcher stated:"...Decisions are being made without consulting grass roots staff and placing both staff and patients at risk for harm...".The third co-researcher shared how a manager was hired without having any orientation to her job. This co-researcher said:

> …I know one (nurse) who would have been fantastic in that (managerial - coordinator) position...who had a history of nursing management, administration; and I was shocked that she didn't get it. But it was given to another person. The person (hired) was not orientated to the floor, is not orientated to the daily

> routines of the facility...could not help the other nurses...could not take over patient care if we need her to, or the Emergency department; which is part of her job description...

These co-researchers indicated that poor decisions were being made by management, with no input from the healthcare team. There seemed to be limited communication between management and the healthcare team regarding things such as who would pick up soiled garbage, decisions for patient care or what type of manager was suited for a specific management job. These co-researchers also seemed to be suggesting that nurses were not valued and experienced oppression. They got into trouble for things they did not know about and had no control over.

Bartholomew (2006), writing about shared governance in the nursing practice settings, encourages managers to empower nurses, since having a voice and being heard reduces workplace violence and ultimately improves patient care. The lack of valuing reported by these co-researchers can provoke conditions ideal for intercollegial violence, can diminish a common vision, negate individual nurse contribution and disempower the whole team.

Post*-Focusing *workshop interview data.

Decision making also came up in the Post-*Focusing* interviews for at least three co-researchers. Their comments during the Post-*Focusing* interview demonstrated a healthy shift from feeling disempowered to feeling empowered. One co-researcher, following the *Focusing* workshop, exercised leadership skills and went directly to the manager with whom she had had the conflict and diffused the situation. This co-researcher said:

> ...Recently a manager telling me that I was suppose to register for this workshop that I had been at and no one had ever communicated to me that we needed to register for the workshop before the workshop... (and the co-researcher went to the manager and said)... okay now I know, how do I go about that next time, is there anything I change now"... So it kind of diffused the situation right away...

A second co-researcher, during the Post-*Focusing* interview, also spoke to decision making regarding the level of care provided to the patient. This co-researcher said:

> ...They (healthcare facilities) have definitely changed a lot. I see a lot less caring about people. It is very much an all about me thing. If I can get away without doing something, if I don't have to go look after that person I won't, it is a very niche oriented place that we have come into. I said to the girls the other day, 'you know it is not about the care of the residents any more, it is about looking after ourselves and that is where the line stops. It is not about caring for the residents it is about being careful you don't do anything that you can get hauled into the office for, being careful you are not going to get threatened with your job.' The care is not there because we can't allow it to be there anymore. We are just protecting ourselves and keeping ourselves out of trouble...

A third co-researcher shared how it could be a threatening experience just to speak out or speak up about things that matter in the nursing practice setting. This co-researcher said: "...and people (healthcare providers) are speaking out, many people are speaking out. And it takes a ton of courage to speak out because (management) won't put it in writing."

A lack of support and/or communication, and/or listening from management will lead to emotional disengagement in the nursing practice settings (Bartholomew, 2006).

Poor healthcare: Mental health of the nurse.

In the Forward to *Little Murders*, Bennis (found in Pearson & Porath, 2009) stated, "These events (incivility) are more than little hurts, irritations, they're more like deaths" (p. x). He goes on to say, "Incivility around the world – I'd call it violence–tends to be heightened when the world is suffering…" (p. xi). Workplace violence/incivility/hostility is a very serious experience and does feel like a little death. Further, I believe that such experiences lead to serious wounding of the nurse. Intercollegial violence, hostility, incivility, bullying, disruptive behaviours etc., affect the physical, psychological, emotional, social, and spiritual dimensions of a nurse's life (Conti-O'Hare, 2002).

Pre*-Focusing *workshop interview data.

The following quotes come from the co-researchers' Pre-*Focusing* interview and address the sub-theme Poor Healthcare: Mental Health of the Nurse.

This first co-researcher was so scared that he could not really remember how he responded to this interaction. He thought he moved away from the upper manager – which sounds like a flight or fight response. This co-researcher said: "…he threatened me (the upper manager) as far as I was concerned … He picked me out of a crowd and scared the poop right outta me…I think I just got out of there...".

A second co-researcher felt devastated and disempowered. She suggested that she was physically, emotionally, socially, psychologically and spiritually wounded. This co-researcher said: "...I'm supposed to go to work with compassion; as a compassionate

person when I've just been ripped to shreds by that HR person (by Human Resources staff)...".

Levine and Frederick (1997) suggested that the above types of experience are just as traumatic and debilitating as those experienced in combat or in child abuse and both of these co-researchers spoke to traumatic events that touched them physically. This falls into the description of a bodily discomfort (Gendlin, 2003b), as the co-researchers did state, "…scared the poop right outta me…" and "…I've just been ripped to shreds…". They talked about how difficult it was for them to be in their practice settings. One shared how she struggled spiritually, "as a compassionate person", while at work. Conti-O'Hare (2002) and Bartholomew (2006; personal conversation, May 2011) both suggest that if these types of traumatic experience are not addressed therapeutically and reflectively, they can lead to Post-Traumatic Stress Disorder. Although nurses generally are concerned about their patients and traumatic life events, they have been slow to address the issue that nursing can be excessively stressful and workplace environments potentially traumatizing.

Post*-Focusing *workshop interview data.

A review of the interviews would suggest that co-researchers, following the *Focusing* workshop, showed movement from being emotionally overwhelmed towards a place of reasoning about what is happening to nurses generally.

The first co-researcher indicated an awareness and concern for the bigger picture in the nursing practice setting. This co-researcher said:

> ...I just had discussions with them (other nurses) and it is obvious that's a concern with them. That workplace violence continues to carry on and I'm one of the

> lucky ones cause I'm not there right now. When I start to think about it, it's a big part of the nursing profession. It's not just secluded: it plays a role. Yeah it's still out there, and it's still happening...

The second co-researcher also focused on the bigger picture - how nursing cares for patients – yet could find nobody to care for or support the nurses. This second co-researcher said:

> …the HR (person) doesn't like nurses. You know, we are supposed to be there for the patients. HR is there for the organization not for the staff and one of the HR people has come out and said that they are for the organization; they are not there for us...

Both co-researchers reported being traumatized by intercollegial violence and both have left their practice settings. However, the above quotes showed a shift from an emotionally overwhelming place to a place of reasoning.

The *Focusing* way of being with a person means valuing all emotions no matter how raw (Madison, 2001) and deeply self-reflecting on these emotions provides the opportunity for listening to the body's wisdom. In Gendlin's paper (2003b), *When You Feel the Body From the Inside, There is a Door*, he explained how this door opens to the body's wisdom and provides tacit information that thinking cannot provide. Further, the intervention of *Focusing* specifically invited the individual to communicate with the body's wisdom so that trauma can be resolved and the person can move forward (Gendlin, 1986, 2003b; 2007).

Poor healthcare: Concern for the patient.

The co-researchers expressed concern for the patient in the midst of ongoing intercollegial violence. Nursing has integrated relational and caring practices as important parts of nursing practices (Benner, Sutphen, Leonard, & Day, 2010); therefore it is the nurses' concern to care about the well-being of the patients at all times.

Pre*-Focusing *workshop interview data.

The co-researchers spoke about concern for the patient in the midst of their own intercollegial workplace violence experiences during their Pre-*Focusing* interviews.

The first co-researcher clearly described how one went into survival mode when experiencing workplace violence, rather than focusing on providing patient care. This co-researcher said: "...You cover your ass - you are in survival mode (as a priority rather than patient care)..."

A second co-researcher shared how workplace violence impeded patient care, affected the patients negatively who witnessed it and caused unnecessary stress for the nurse involved. This second co-researcher explained:

> ...A person from HR came down to my work area and stood at the general open door of the waiting room which was packed with patients and families, and I was looking after a patient - a poor gal - doing some nursing care with her and she was in a wheelchair and I was bent right down. She was whispering to me, like she had just no strength at all. Anyway, the HR person was in the doorway with his hand on the door and a file under his arm and he is snorting and tapping his foot, and switching his binder. The patient kept looking at me and said, 'I think he is trying to get your attention'. I said, 'Well he can wait, what we are here for is the

> patient'. The patient is telling me that she just can't do it anymore: 'My family wants me to keep fighting. They want me to go for treatment; I'm so tired'. My head was right down by hers and I was talking to her, while the HR person was doing his thing in the background. So I looked up and said, '…I'm really busy' and the HR person said, 'Well you know that meeting we had…". That patient I was looking after died six days later...

A third co-researcher related how the patients were deeply affected by workplace violence: they were so affected that they had lost their joy and it seemed challenging to get the patients to experience some happiness. This third co-researcher said:

> ...indirectly it has affected them (the patients) big time; we have got so many good patients. They are really fun to be with, but I see them withdrawing, not wanting to participate, not wanting to do things. Yah big time no joy or happiness with the patients and it's really hard to get them going on that again; like it's a struggle...

A fourth co-researcher was concerned about patient advocacy and the lack of it. This co-researcher said: "...We really do not know how to lobby for better healthcare for the patients...".

Parsons, Robichaux and Warner-Robbins (2008) in their participatory action research paper stated that, "Effective promotion of the well-being of others requires development and cultivation of a virtuous character within a supportive environment" (2008, p. 75). These authors discuss the virtue of nursing and see nurses as a moral community that promotes the well-being of the patients with caring behaviours and compassion. However, the co-researchers were saying that this was very difficult to do in an atmosphere of hostility and conflict. Being a patient advocate (as part of caring for the

patient) was also difficult to do and viewed as risky. Through advocating, a nurse could end up in an intercollegial hostile situation. Conti O'Hare suggested that nursing be viewed as "a wounded profession" (2002; p. vii), as nurses are unable to stop intercollegial violence nor can they use their voices in national and public policy debates for patient advocacy. Nonetheless, these four co-researchers stated concern for patient care.

Post*-Focusing *workshop interview data.

During the Post-*Focusing* interviews, these co-researchers demonstrated a shift from being helpless in providing quality patient care while experiencing ongoing workplace violence, to being hopeful about nursing, being more knowledgeable about workplace violence in practice settings, and how to prevent this, thereby enhancing patient care.

One co-researcher indicated some hope that nursing was becoming aware and knowledgeable about the effects of workplace violence and how this awareness could bring more caring to the nursing practice settings. This first co-researcher said:

> ...I think the abuse could still continue, where it's changed, I think, that we're bringing up a new set of nurses that are better equipped and are more knowledgeable…To realize how hurtful they can be and take that into consideration…Therefore the young ones (managers) now are coming up more caring...

A second co-researcher clearly indicated that, following the *Focusing* workshop, she felt empowered to advocate for quality patient care and she knew that this was the right thing for her to be doing. This co-researcher said:

> ...Since the short time that I met with the researcher and had the *Focusing* workshop, I would say the one incidence I am thinking of has occurred since. I felt better about it; quicker after than I would have probably before; and just feel more positive about myself and my motives in what I am trying to be and act as a nurse. I feel good about myself because I feel like I am in the right place and realize also though that being a nurse sometimes involves advocating (for the patient) and you have to act at a certain professional level. There is going to be conflict because sometimes you are going against actions or certain things you do have to advocate. I guess I feel empowered in knowing what I am doing - I believe is the right thing...

The third co-researcher explained that her being listened to during her interview while she was venting helped her become clear about her intercollegial workplace violence situation. This listening and caring for her empowered her to go to her nursing practice setting and give quality care to the patients. This co-researcher said:

> ...I think just venting and seeing that I am not crazy, and these things are happening, I can go to work and say I know there is going to be something happen, but I know I can deal with it. I can deal with it, cause I know I am not the crazy one. Really my concern is with the residents...

These quotes clearly reflect the nurses continuing struggle to provide safe, competent, compassionate and ethical care in a hostile environment. However, the Post-*Focusing* comments seemed to be more optimistic in nature; although there was still considerable concern for patient care.

Poor healthcare summary.

The co-researchers seemed to experience an on-going struggle to maintain an acceptable level of patient care and advocacy in the midst of considerable intercollegial violence. This struggle, in itself, stressed them. During the Post-*Focusing* interview, the co-researchers remained concerned about the quality of patient care. They also demonstrated clear behavioural changes, as they found a voice with which to state their concerns and found the courage to be a patient advocate.

The literature suggests that valuing nurses and supporting their voices adds to a pool of wisdom and decreases oppression, thus minimizing intercollegial violence. Sharing power, holding a common vision, acknowledging unique contributions and valuing every team member creates an "infinite amount of power (that) becomes available" (Bartholomew, 2006, p.156). In a nursing practice setting where this power was available, healthcare providers would have the energy to provide excellent care to patients and would experience professional and caring intercollegial relationships. This would be a win-win situation.

Theme 3: Resiliency

Resiliency involves one's "ability to rebound" and the "capacity to bounce back, to withstand hardship and repair yourself" (Wolin & Wolin, 1993, p.5). Further, O'Connell Higgins (1994) suggests that individuals who are resilient demonstrate creativity, exceptional empathy, sound ego development, commitment to self-reflection and good long-term relationships. They milk the best from any unfortunate life situation and "maintain strong political and social activism" (O'Connell Higgins, 1994, p. 20). The

theme Resiliency includes the sub-themes: ‘Insight, Wisdom and Awareness’; ‘Creativity and Humour’; ‘Healthy Relationships’; and ‘Self-Efficacy’.

Resiliency: Insight, wisdom and awareness.

Insight, when applied to relationships, can be viewed as an intuiting or sensing by observing closely what the other person is saying or not saying, his/her tone of voice, physical appearance and dress, breath, breathing rhythm and walking patterns (Wolin & Wolin, 1993). Wisdom, on the other hand, comes directly from experience and knowledge (Fjelland & Gjengedal, 1994). Wisdom comes from the “physically-felt body” (McMahon, 1993), such as in the cliché ‘I have a gut feeling about this’. Or, as Ferguson (1980) suggested, wisdom is the “…capacity to summon buried wisdom, holistic in its respect for the ‘felt-sense’ of the problem…” (pp. xv – xvi). Brown talks about awareness as “…knowing something exists, critical awareness is knowing why it exists, how it works, how our society is impacted by it and who benefits from it” (2007, p. 93). Brown goes on to explain that awareness increases one’s consciousness and understanding.

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interview three co-researchers discussed their insights, wisdom and awareness regarding their intercollegial violence experiences.

The first co-researcher found wisdom and critical awareness in making the choice to go to court and that choice impacted on other co-workers. He said: “...I feel I am definitely a better person for what I did …going to court and saying my truth…probably the biggest help was getting out of the workplace…I’m going to take something positive out of it, I feel good about supporting my co-workers...”.

A second co-researcher shared her insight, awareness and wisdom as she has developed the skill of not worrying about tomorrow. She said: "...I guess what keeps me balanced is that I work in two areas…It seems like you can move forward again once you can vent and get it out…I also realized I don't have to worry about tomorrow or the next day, just this minute...".

A third co-researcher provided the following insight and awareness about the effects of workplace violence on her quality of care. She said: "...I am realizing that probably there are instances where I could have probably done better but because you don't feel good about yourself - you don't...".

These co-researchers demonstrated insight into their feelings, wisdom in the choices they made, and awareness about the outcomes for their choices when intervening with workplace violence situations. The above co-researchers took a risk in dealing with conflict, or chose to prevent conflict, or knew that they could have done better in hindsight. They showed awareness of their strengths and limitations but also the wisdom to handle these situations.

Post*-Focusing *workshop interview data.

The co-researchers showed insights, awareness and wisdom in the Pre-*Focusing* workshop interview but also demonstrated a significant shift in becoming more resilient during the Post-*Focusing* interview.

The first co-researcher shared how his critical awareness had been sharpened during the Post-*Focusing* workshop interview. He said: "...I have been equipped and I know how I can affect a young new coming nurse...".

A second co-researcher gained insight into her motive for nursing and awareness of her feelings of confidence. She obtained clarity about herself and her inner wisdom, and about what she represented in the nursing practice setting. She said: "...I felt better about it; quicker (after the *Focusing* workshop) than I would have probably before and just feel more positive about myself and my motives in what I am trying to be and act as a nurse...".

Following the *Focusing* workshop, a third co-researcher shared her insights, critical awareness and wisdom. This co-researcher sought to return to her authentic Self and indicated a transcending process had been initiated since her *Focusing* workshop experience. She said:

> ...I think that the *Focusing* session on Sunday helped me to realize, to relax a bit... to be more in tune with myself. I said to my husband, 'I know my personality has changed in the last year working in there; I know my attitude has changed … and that is not fair to anybody.' You know, I need to learn to deal with the work situation and leave them there and make sure that I don't change because that is not what I want to do. I don't want to become somebody that she has intimidated me to become; I want to stay true to myself. So that the *Focusing* session was good, it made me more aware...

All three of these co-researchers have embodied wisdom, awareness and insight into their professional and personal lives. The benefits from *Focusing*, relevant to the above co-researchers' experiences, assisted them to become aware and to gain insight into their life situations. *Focusing* assists the person to tap into her/his inner bodily wisdom, and thereby, connect to her/his authentic Self.

Resiliency: Creativity &humour.

Creativity comes from one's imagination and makes "nothing into something" (Wolin & Wolin, 1993, p. 163) and humour turns some difficult things into silly nothings. Both these acts come out of a sense of play.

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interview three co-researchers made statements containing both creativity and humour which are elements of resiliency.

One co-researcher showed a creative attempt to protect the patients from the manager who was spying on her that had a tone of playing musical chairs. She said: "They were spying, so I closed the dining room doors and moved all the tables (and chairs) into a little corner...".

A second co-researcher seemed to indicate that she would rather be creative than work in an ongoing hostile environment. She also pointed to the fact that creativity was one of her spiritual practices. She said: "...I'd rather do something creative…creativity has spiritual value...".

A third co-researcher said that her hostile nursing practice setting produced victims; however, she and the patients would laugh and giggle in the midst of the workplace violence. Therefore, both the co-researcher and the patients used humour to make their nursing and patient experiences more bearable. This co-researcher said: "…it's a victim culture; I can make jokes about it…We had patients laughing and we would giggle…".

Post*-Focusing *workshop interview data.

During the Post-*Focusing* workshop interview, the co-researchers showed an increase in their resiliency through sarcasm, creative imagination and by developing a larger Self.

One co-researcher expressed sarcasm about getting into trouble for caring – something the nurse embodies as part of her nurse identity: "...It's amazing some of things you get in trouble for, for being nice to the patients and it's like, well it's my job but they really don't encourage it at all...".

A second co-researcher seemed to be laughing at the organization that provided her with a very severe workplace violence experience. She talked about her wonderful, creative and purposeful life outside of the nursing practice setting. This co-researcher said:

> ...I had a sense that they @#!* me over and the lack of support; but I have a wonderful life. I don't have to work, I read, do my crafts, my knitting and if somebody wants I can help with a funeral lunch, I can drive someone to an appointment or go to a jazz seminar. So I have a wonderful life...

A third co-researcher used creativity to develop a larger Self with inner children that love to play. This co-researcher demonstrated a transcending process as she said: "…I think the (fox) pups (from the metaphor interview) represent a creation of inner children…It's like a creative thing...".

What caught my attention with the above quotes was that creativity and humour seemed to provide the co-researchers with substance and stability – something that their

environment could not destroy; something that came from or added to their authentic Self.

Resiliency: Healthy relationships.

Resilient people tend to foster strong, mutually respectful, long lasting and caring relationships (Bandura, 1999; O'Connell Higgins, 1994; Wolin & Wolin, 1993). The co-researchers became role models and change agents in their belief of fostering healthy relationships.

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interview the co-researchers spoke about their professional and personal relationships. One co-researcher talked about his collegial relationships with his co-workers and how he was acknowledged as a model for them. He also talked about how important relationships had been when going through his workplace violence experience. This co-researcher said: "...I'm well respected by my colleagues or by co-nurses for what I did…the support I received of my wife was huge...".

Similarly, a second co-researcher talked about her caring relationships and about fostering healthy interactions, indicating a healthy work-life balance. She gave to the patients, and the patients responded in kind. This co-researcher said: "…we actually had a pretty darn good time there…family members came in and said, 'It's good to have you here…'".

A third co-researcher was recognized by her co-workers as a change agent. She said: "…the girls (co-workers) have all said it is about time somebody stood up to them...".

A fourth co-researcher also talked about being a change agent and commanding respect from her colleagues. This co-researcher said: "...I did start something and I think that a lot of people were actually more respectful towards me afterwards...".

These four co-researchers developed healthy relationships with their colleagues, their patients, and their significant others. They were role models, standing up to the workplace hostility and demanding respect. This is a powerful demonstration of resiliency in light of the trauma they experienced in their workplaces.

Post*-Focusing *workshop interview data.

During the Post-*Focusing* interview the co-researchers translated their Pre-*Focusing* workshop resiliency in their workplace to a resiliency within the larger community.

One co-researcher translated his personal resiliency and knowledge of healthy relationships to his practice setting where he is now the manager. This co-researcher, as a manager and leader, articulated his values to his staff, thereby modeling healthy collegial behaviour and fostering long term relationships. He said:

> ...I'm saying to my staff, 'You know what, if you guys have any issues with me whatsoever, you bring them to me'. I leave the door open all the time and say, 'You know what, if I wrecked your day or I did something you didn't like, please let me know and I will address it...

A second co-researcher would like to maintain a healthy relationship with her manager, despite the manager's bullying behaviour towards her. This co-researcher demonstrated leadership skills such as listening, high level communication and conflict

management skills, all of which foster a healthy collegial relationships and model conflict resolution behaviour for the manager. She said:

> ...Still specifically there seems to be a need to bully as in a manager that we have currently. I guess I find with her, by just calling her right away, on what she is saying, seems to diffuse her, taking responsibility on my part with the issues where she is trying to attack me or have something over me, seems to help diffuse the situation. I think about communication, listening, being the listener to the person that is talking to pinpoint... exactly what they are saying to me. What is their message behind the words?...

A third co-researcher moved from fostering a one-to-one relationship, to fostering a community of healthy relationships where everyone is safe to be his or her own Self despite the workplace politics and hostility. Further, this co-researcher stayed true to her caring, compassionate resilient Self, modeling to the patient and the community that quality of embodied being-ness. This co-researcher said:

> ...There was a gal who died a few years ago. She was nineteen when she died of leukemia. She was the older of two girls and her parents were quite young and they were just so devastated by this terrible disease, but anyway when that gal would come into the agency. She would flop into the chair, take off her wig and she was kind of at home. ...Everybody (in the nursing practice setting) just treats her like everybody else; she can just be herself and yah, it is a real little community in there. So I really miss that but when I think of all the politics in just about any job these days, I don’t want to be a part of that...

Resiliency: Self-efficacy.

Self-efficacy is the person's sense of their own mastery in life situations. A sense of Self-efficacy requires resiliency to overcome or bounce back from adversity. As Bandura (1999) states,

> Developing a sense of efficacy through mastery experiences is not a matter of adopting ready-made habits. Rather, it involves acquiring the cognitive, behavioural, and self-regulatory tools for creating and executing appropriate courses of action to manage ever-changing life circumstances. (p.3)

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* Workshop Interview all five co-researchers commented, in some way, on their self-efficacy skills. One co-researcher showed determination in mastering his response to his workplace violence experience. He said: "...I'm going to work this out; I don't care what it takes. I'll figure it out. I'll do it…So it would be my responsibility to take it outside to a therapist or someone...".

The second co-researcher talked about how she tried to calm herself down when anxious, which for her was a developing Self-mastery skill. This co-researcher said: "...I have the tools now, if I feel anxious I try to calm myself down...".

A third co-researcher discussed standing on her own, following her own values, sorting out her own possibilities for responding to her environmental experiences. She said: "...I don't care if someone supports me, it has to be what I can live with myself…I'll investigate under every rock and see what my options are and then go from there…".

A fourth co-researcher also knew that she could stand on her own. She demonstrated problem solving abilities to resolve her workplace violence experience.

This co-researcher said: "...I can hold my ground if I have to…I have also started going into the website and checking into the law...".

The fifth co-researcher also stood up for her beliefs and values. She knew her own strength – her own mastery of how to deal with her workplace violence situation. This co-researcher said: "...I will stand up for what I believe is right…Always returns to sense of self through my value of caring; I know there is strength in me...".

The above quotes demonstrate mastery in finding out how to resolve painful life situations, how to keep grounded during stressful experiences, how to face adversity alone and how to draw from inner strengths. If the co-researchers felt they did not have the skills to overcome their workplace violence experiences, they talked about seeking outside support, emancipating from their environment, following their values and taking responsibility for adapting to this unfortunate hostile environmental communication exchange (Bandura, 1999). Heidegger would say that these co-researchers had to take a stand for themselves within the context of their workplace environment situation (Leonard, 1994).

Post*-Focusing *workshop interview data.

During the Post-*Focusing* interviews all five co-researchers talked about expanding their Self-efficacy skills, using their mastery skills in other areas of their life, resolving past issues, recognizing the outcome of their Self-efficacy skills (such as leadership skills). The first co-researcher said that he would deliberately work at making changes in the workplace, and more so following the *Focusing* workshop. One co-researcher said: "...I would be an even bigger voice. I would make changes from the

bottom up and given the chance to manage again I might even do it and make changes from the top down...".

A second co-researcher talked about how the *Focusing* workshop permeated both her professional and personal life and helped resolve unfinished business. This co-researcher said:

> ...I found the *Focusing* workshop to be beneficial, that the interaction that I had with the researcher, conversation during the interview and the workshop were very very positive and had helped me not only professionally in my work experience, but in my personal life too. It had kind of given me some answers to some undone or unfinished business...

A third co-researcher talked about how her Self-efficacy skills translated into an organizational outcome; the changes in the Human Resources policies were enormous. This co-researcher said:

> ...It's interesting…the union gal and the fellow both said to me, 'You have made unbelievable changes in the agency as far as the HR policies go and when something comes up, they deal with it right away and there has been countless changes'...

A fourth co-researcher talked about her insights into her workplace environment and that she was able to make a stand for her Self and her patients (Self-efficacy skills). This co-researcher said:

> ...I just think venting and seeing that I am not crazy and these things are happening, I can go to work and say I know there is going to be something

happen, but I know I can deal with it, cause I know I am not the crazy one. Really my concern is with the residents...

The fifth co-researcher found that her Self-efficacy skills were being noticed by her nurse colleagues. This co-researcher said: "...I think I was one of the first ones to initiate some sort of conflict resolution and then other nurses did as well...".

Following the *Focusing* workshop, the co-researchers enhanced their Self-efficacy skills through purposeful self-reflection, behaviour changes and cognitive thought processes. All of them talked about expanding their self-awareness, self-regulation skills, embodied goals and coping and adapting skills, thereby influencing their environment for the good of all (Bandura, 1999).

Resiliency summary.

There seem to be several common threads running through the Pre- and Post-*Focusing* interviews. The co-researchers showed awareness of the importance of how their colleagues and patients perceived them. They seemed to be committed to developing deep, meaningful and healthy relationships with all of their colleagues, thus making the world a larger and better home for everyone (O'Connell Higgins, 1994). Further, creativity and humour seemed to be an integral part of how they responded to their work environments. As well, the co-researchers demonstrated mastery of skills such as coping and adapting to an unpredictable and hostile environment in both the Pre- and Post-*Focusing* interviews.

Theme 4: Embodied Spirituality

Within the healthcare literature, the notions of spiritual health and spirituality seem to be intertwined (Cassar & Shinebourne, 2012; Gardner, 2009; Koenig, 2011).

Spirituality is considered “an internal force... (and) a process” (Cassar & Shinebourne, 2012, pp. 136-137), and involves finding purpose in one’s existence. Spiritual health is spiritual development and growth (both spiritual processes) that provides the person with guidance for being and doing (internal force). A recent overview of spirituality and health research found a positive relationship between religion/spirituality and both mental and physical health (Koenig, 2011). Spirituality involves finding purpose in one’s existence. For spiritual health, one’s values must be embodied and carried forward (Hinterkopf, 1998) in life for transformation and transcendence to occur. For spiritual health, it is important to connect with Self, others, one’s larger power/God and to become more conscious as one reflects from life experiences (Conti O’Hare, 2002; Scott Barss, 2010). For the purposes of this research project, embodied spirituality means listening to the body’s wisdom and connecting to one’s larger (higher) power to find significant meaning and substance (Campbell & McMahon, 1997; McMahon, 1993). For this theme of Embodied Spirituality, the sub-themes were: ‘Dead Ends’, ‘Loss of Self and Grieving’, and ‘Shame and Suffering’.

Embodied spirituality: dead ends.

Gendlin (1996) suggests that humans experience two kinds of dead ends when they are stuck in a life challenge. The first is when the individual interprets her/his problem situation as a ‘nowhere-to-go experience’ or as a failure to move forward in life. In other words there is no ‘experiential process’; the individual cannot think his/her way out of a problem. The second dead end is when the individual experiences the same emotions or bodily feelings over and over again, such as pain in the chest or butterflies in the stomach. McGavin and Weiser Cornell (2011) have further developed the notion of

dead ends into the concept of ‘tangles’. Tangles can be experienced as extremely complex situations where different parts of a person’s psyche are battling, leading to dispiriting feelings of powerlessness, hopelessness and helplessness. McGavin and Weiser Cornell suggest that tangles emerge from either “failure to meet an overwhelming situation” or “rejection by those who are important to us” (2011, p. 4). This would resonate with findings from the co-researchers’ intercollegial workplace violence experiences. Workplace violence has many facets, is very complex, and is exceedingly overwhelming to those caught in its web. Further, these co-researchers did experience rejection (Bartholomew, 2006; di Martino 1993).

Hinterkopf (1998) would say that dead ends (or what Hinterkopf calls stuck structures), with their dispirited feelings of helplessness, hopelessness and powerlessness, have the potential to change, to become unstuck and to transform, when a *Focusing* approach is applied to them. There may be times where a spiritual process could unfold through the use of a *Focusing* intervention. A spiritual process "involves paying attention to a holistic, bodily feeling (a felt sense) in a special way that allows the unfolding of greater easing and life energy" (Hinterkopf, 1998, p. 69). This process allows us to embrace more of ourselves, others, and life. And it allows for more hope, faith, and strength.

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interview, all the co-researchers shared their personal experiences of dead ends and below are three examples:

One co-researcher clearly demonstrated a dead end situation and spoke of his feelings associated with it. This co-researcher said: “...unable to fix this problem or this

issue that I had; I felt like a failure: there was nothing I could do…I felt threatened and I bowed to it...".

A second co-researcher talked about her dispirited feelings of hopelessness and how she only had energy to take care of herself. This co-researcher said:

> ...definitely hopeless. You know I kept thinking when I retire I want to do something for the community; I want to put something back in. And lately you know what I am just thinking I want to get through, I just want to sleep, or I just want to go look after myself...

A third co-researcher shared her dispirited feeling of powerlessness and the dead end of not being able to move forward. She said:"...I have a feeling of powerlessness…like I cannot move forward...".

Two other co-researchers said that they would never again put themselves into such a painful situation. One had given up nursing in healthcare facilities and the other deliberately avoided 'any smell of conflict' in her healthcare facility. Her major goal at work was to stay out of the fire.

Post*-Focusing *workshop interview data.

Dead ends can initiate the beginning of a spiritually transcendent process. The following quotes are from the co-researchers after their Post-*Focusing* interviews and demonstrate a transformation and or transcending process. One co-researcher talked about his experience of a transcending process from feeling trapped with no support to being able to voice his experience publically with minimal effect. This co-researcher stated:

> …I recall feeling trapped and not wanting to go to anybody cause I'm the man of the house…and I couldn't understand how somebody could do that to me… I started to think, oh my gosh, that was a horrible experience…if I was to do the exact same interview (with the researcher since the post-*Focusing* workshop), it wouldn't affect me as much; it doesn't hold as much power in me anymore; I could stand up in front of a microphone, in front of a crowd of people and tell people what I went through. I wouldn't feel as intimidated...

A second co-researcher talked about how she felt safe and worry-free, able to express her dispirited feelings, which demonstrates the beginning of a transformational process. She said:

> ...Probably being able to vent to somebody outside, letting somebody else know what we are going through, because everything is suppose to be confidential and it is hard to work where you can't say to anybody, this what they are doing to me and so makes me feel bad …so it has been good to be able to vent to somebody outside of that, somebody you could say what you feel and not worry about it...

A third co-researcher demonstrated a transformational and transcending process by developing a psychological boundary and being able to make a stand for herself. She was not at a dead end; rather she was able to engage with a problem situation with self-confidence. This co-researcher said: "...I try not to take it personally…I think I would put up with less now...".

These co-researchers seemed opened to "the healing of grace" (McMahon, 1993, p.62) as they listened to themselves through storytelling, self-reflecting and the

experience of *Focusing*; thus they transcended their dead ends. As McMahon (1993) states,

> Violence inevitably erupts over and over again in a culture that does not have its fundamental character grounded in a body experience of the unity and gift-dimension of all life…We must re-own our body's consciousness as a bridge into the Larger Body (greater power) and its wisdom. We must discover a body-spirituality, a 'bio-spirituality' for the twenty-first century... (p. vii)

The Bio-spirituality community suggests that there is a bridge between humans and the larger body (larger power/God), which is recognized as a connection with the Divine (Campbell & McMahon, 1997; McMahon, 1993). It would seem that just such a spiritual connection helped these co-researchers engage in a healing process.

Embodied spirituality: Loss of self and grieving.

Nouwen (1979) talks about the "image of the wounded healer" (p. 4) and believes that the wounded healer loses parts of Self. The co-researchers shared their experiences of being wounded by workplace violence, which inevitably caused loss of parts of Self, which in turn led to a grieving process. Woundedness and grieving created in the co-researchers a feeling of no future. Loss of Self within the context of this research project means losing the capacity: to interact with one's environment to meet challenges in the world; to be confident; to have clarity and to see the larger picture. Loss of Self results in losing the sense of being empowered, grounded, centred, and peaceful (McGavin & Weiser Cornell, 2011). Grieving, within the context of this research project, is defined as the experience of losing something that matters to the individual. The experience of many losses, the loss of a safe and enjoyable workplace, the loss of colleagues, and the possible

loss of one's livelihood, would produce layered grieving and suffering (Purnell, 2007). Grief and suffering go hand-in-hand (Purnell, 2007) and grief does not disappear overnight; in fact grieving and suffering return over and over again (Moules, Simonson, Prins, Angus & Bell, 2004).

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interview, three of the co-researchers expressed their personal loss of Self and discussed elements of grieving. One co-researcher talked about loss of Self-concept and professional identity and grieved the loss of his previous Self-efficacy/mastery skills as he recognized his overwhelming vulnerability. He said:

> ...professionally as a good nurse, I couldn't do that anymore; that got taken away from me... Now personally, I was now vulnerable and it was the first time in my life I felt like an average Joe...I would definitely say that I am not invincible; and before that I thought you know, I could get through a lot of stuff, no problem; I am not as tough as I think I am...

A second co-researcher talked about a part of her that had died and said that she was now grieving the loss of her value of providing quality care to the patients. This co-researcher said:

> ...I'm here for the patients to make their lives better, because it's boring in there and it's depressing. I am here to try and change that as much as I can. And I guess that part of me had kind of died....

A third co-researcher clearly stated during the end of her Pre-*Focusing* interview that she was in a grieving process and at loss of what to do with her grief. She said: "...I guess I am grieving and I just don't know what to do with the grief...".

A fourth co-researcher on three occasions shared how she would leave work with tears streaming down her face due to the experience of being shamed, which triggered a wound and loss of Self. Her tears were signs of grieving.

Clearly, from the above quotes, it can be seen that the co-researchers experienced a threat to the integrity of their Self. Parts of the Self had died and clearly the co-researchers were grieving.

Post*-Focusing *workshop interview data.

During their Post-*Focusing* interviews, three co-researchers showed they had shifted from the loss of Self, grief and the sense of no future, to finding support, protecting themselves from being re-traumatized again, and the return to their values and authentic Self.

One co-researcher appeared to be talking about not dealing with loss of Self: the experience was too intense and he did not want to cry. It was not manly. However, he is married to a woman who could support him through his grieving process. This co-researcher said:

> …if given the opportunity, I'll probably stuff it and carry on, or not talk about it as much as I should. I know deep down I have to talk about these things, but I don't have time or whatever excuses. The big events like this (workplace violence) one – that is very intense; I don't know how to deal with that…I'll put it on the back burner. My wife knows better and she sucks it out of me...

A second co-researcher sought out other nursing opportunities, which demonstrated some courage and healing; however, she believed that she could not put herself through another traumatic workplace violence experience again. A large part of

her was protecting herself from this, and she said: “...it has hurt me, I have no confidence left. I did apply for jobs and got as far as an interview and I don’t think I could go through with something like this again...”.

A third co-researcher had excavated her kind Self; she was returning to her authentic, kind Self which required tremendous courage. Following the *Focusing* workshop, this co-researcher seemed to be engaged in an unfolding of greater life energy. She had surrendered to a healing process which allowed her to embrace more of her Self, others and life. This demonstrated strength, courage and hope.

> ...I have learned that it is up to me, like I have to be the one who is comfortable with myself; and if I am not comfortable being kind, I am not being true to others so that I can be true to myself. That’s who I am; that’s my personality...

As I reviewed the above co-researchers’ statements, I interpreted that the co-researchers were involved in processes of becoming whole again. They showed great courage by returning to their values of caring for Self and for others. They acknowledged their possibilities and their relationship responsibilities which brought them back to their authentic Selves. One co-researcher acknowledged that once he had let go of his hurt and denial, he could acknowledge his grief by talking with his significant other. This act of intimate sharing is essential to self-transcendence. Watson (2002) suggests that it is not possible for wounded nurses to become the nurse-healers they are destined to be unless they acknowledge the hurt and loss they have experienced.

Embodied spirituality: Shame and suffering.

As the researcher, through my embodied interpretation of the co-researchers’ suffering, I could recognise the condition of the suffering human, the suffering nursing

community, and the suffering of the world (Nouwen, 1979; Pearson & Porath, 2009). Grieving, loss of self, dead ends (discussed earlier) and shame are all causes of suffering (Brown, 2007; Conti-O'Hare, 2002; McGavin & Weiser Cornell, 2011; Purnell, 2007). Brown (2007) suggests that we live in a culture of shame and are constantly shaming one another in a bid to control others' behaviours. Barrett (1996) wrote extensively about the meaning and qualities of suffering. For her, suffering is different than pain. Suffering is more tenacious and intrusive than pain. Further, suffering (and not pain) permeates all aspects of one's life (e.g. physical, psycho-social, and spiritual), but also implies the possibility of transformation. She posits that suffering is disagreeable, distressing, has an excruciating quality, and is caused by loss or change (loss of Self, grieving, dead ends and shame). Suffering brings on embarrassment and shame, and then shame brings on suffering; it is a vicious circle.

Suffering and shame seem to be inescapable for human beings (Barrett, 1996; Brown, 2007). Shame is something most people do not want to talk about and is a very sticky and challenging human condition to deal with; and shaming behaviours are directly related to workplace violence. Barrett (1996) described suffering as meaningful, since "…to suffer is to be present to one's experience, to allow it, to carry it, to give it its voice…especially when it is difficult or uncomfortable" (p. 6). As Brown (2007) explains, "Shame is an emotion…When we are in shame, we don't see the big picture; we don't accurately think about our strengths and limitations. We just feel alone, exposed and deeply flawed" (p. xxii). Therefore, we feel loss of Self and do not feel we belong (Bartholomew, 2006). Shame is a destructive force in our culture. Shaming behaviours include bullying, mobbing, harassing, disrespect, non-constructive criticism, scape-

goating, intimidating, threats, gossiping, nit-picking, the silent treatment, gesturing, posturing and the denial of basic human needs (Brown, 2007; CNA, 2010; di Martino, 2003).

Pre*-Focusing *workshop interview data.

During their Pre-*Focusing* interviews, all of the co-researchers indirectly or directly talked about shame and suffering, but three explicitly shared their shame and suffering experiences. One explicitly talked about his shameful experiences being ongoing and about the degree of suffering he embodied through his intercollegial workplace violence experience. This co-researcher said: "...I had to cower when I walked down the hallways…I had to cry on my wife's shoulder…it was bad all the time; it was bad…".

A second co-researcher talked about her embarrassment, her being scape-goated and how her experience of shame and suffering permeated most of her life. This co-researcher said:

> …that's embarrassing you know and like I don't want that attention…So I was kinda the bad guy all the time; I'm the one bringing up all this stuff…I can do my job with patients and families, but on the way home tears would just stream down my face; I stopped going to yoga after work because the tears would just roll down my face...

The third co-researcher talked about the collective shame of her and her colleagues; they were made to feel unworthy of a livelihood. This co-researcher said: "…we were all led to believe that we were all bad nurses and none of us deserved our pay and none of us should be working…". This co-researcher felt publicly shamed, and was

explicitly told that she was shameful and did not deserve pay or a livelihood. This led to considerable suffering: she experienced feeling flawed as a human being and felt rejected from the nursing (human) community.

Post*-Focusing *workshop interview data.

Three co-researchers continued to address their shame and suffering during their Post-*Focusing* workshop interview. These co-researchers demonstrated a shift from experiencing excruciating shame and suffering to being able to move through the shame and remain true to their values and Self.

This first co-researcher talked about how shame caused by a person's abuse of power could manipulate others to feel, think and behave differently; therefore a person would become someone she/he was really not. Clearly this is loss of Self. This co-researcher said: "...Well when I think about the policy structure in the workplace and really that's around issues of power and my perspective is, when you are in a position of power, you don't use that power to manipulate others…".

A second co-researcher was criticized and rejected (or shamed) for being kind to the patients; however, she did not withhold those acts of kindness – she remained authentic and true to her Self. This co-researcher said:

> ...Aesop was the author of the Wind and Sun Fable and his stories have a bit of morality to them. With kindness, people are drawn out a little more. I have noticed in my nursing practice that I have been criticized by my co-workers who say, 'Oh you shouldn't let the patients talk so much; you shouldn't let them go on and on'. It doesn't hurt to be kind to them; it just kind of validates and gives them some time and I think that does a lot for people just to listen and touch them...

A third co-researcher talked about the quality of her shame and suffering experiences. Again, criticism about being nice and kind did not stop the co-researcher from being her authentic kind Self for the benefit of the patients and herself. As she explained:

> ...It makes you feel down, it makes you feel worthless, it makes you feel like why am I trying, you know, like why do I care. I have had nursing staff say to me, stop being so nice; you are making the rest of us look bad. I'm not that nice, but really you could pick up a little bit. It kind of makes you feel bad and that you are being singled out. It makes it tougher to go to work sometimes...

During the Post-*Focusing* interviews, the co-researchers talked about struggling to be their authentic Selves. It seemed that they were in a transformation process, trying to escape the spell of workplace violence, their shame and suffering, and move toward a more detached and wider understanding of their painful experiences. Most of all they seemed to be making conscious choices to be aware of the misuse of power, to be kind in the midst of criticism, and to strengthen their authentic Selves.

Embodied spirituality summary.

Brown (2007) suggests that shame is a relationship feeling and often stops us from doing things that we think are right to do (such as being nice to patients), especially if the informal and formal cultures do not condone or encourage these acts of kindness (such as in the examples above). Shame is sticky suffering and is not easily resolved; memories of shame can last seemingly forever. Shaming behaviours equate to abuse of power, making others feel worthless, bad, unworthy and rejected. Once you feel intense shame in front of others, you will do almost anything to avoid it happening again.

However, these co-researchers were able to articulate their wounds, were able to take steps towards healing and were able to continue being the best nurses possible, despite the shaming each experienced within the nursing culture.

Theme 5: Embodied Caring

Embodied caring can be viewed as, "a species activity that includes everything that we do to maintain, continue and repair our 'world' so that we can live in it as well as possible" (Hamington, 2004, p. 3). Embodied caring involves ourselves, our bodies, and our environment, all of which exist in a "complex, life-sustaining web" (Hamington, 2004, p. 3). Embodied caring "denotes an approach to personal and social morality that shifts ethical considerations to context, relationships and affective knowledge in a manner that can be fully understood only if care's embodied dimension is recognized…" (Hamington, 2004, p. 3). We humans are wired morally to care for our bodies, our environment, our Selves and one another; consciousness of embodied caring involves recognizing our interdependence and our interconnectedness. Mayeroff (1972) speaks about "living in *faith"* (p. 101). He suggests that caring for others answers a need for the caregiver because from such caring comes growth. The caregiver is "being in faith, and …is rooted in the world" (Mayeroff, 1972, p. 101).

Nursing embodies caring in the following way: "Caring Science is the essence of nursing and the foundational disciplinary core of the profession" (Watson, 2008, p. 17). Caring, then, informs nursing as a profession and includes:

a) human processes and connecting with one another; "Carative Factors/Carative Processes that facilitate healing, honours wholeness, and contribute to the evolution of humanity" (Watson, 2008, p. 17);

b) inner peace and forgiveness that transcend life's traumas; accepting humans as 'becoming' (Parse, 1999);

c) one human being present with another in the caring therapeutic relationship (Parse, 1999); and

d) a moral, scientific, and social stance (Benner, Sutphen, Leonard & Day, 2010; Hamington, 2004; Parsons, Robichaux & Warner-Robbins, 2008).

The sub-themes for Embodied Caring are 'Conflict Resolution', 'Embodied Caring for Self and Others', and 'Safety for Self and Others'.

Embodied caring: Conflict resolution.

Conflict resolution can be viewed as a caring behaviour because it is an embodied caring principle of repairing the world so that humans can live as well as possible. Conflicts, according to the teachings of Sartre, are possible in almost every moment-to-moment interaction and can be viewed as positive insofar as they bring forward choices, resolutions or some kind of management (Strasser & Randolph, 2004). Conflicts can be seen as part of the human condition and have an evolutionary purpose – assisting people to move forward. Conflict resolution/management within the context of this research project can be viewed through Carl Roger's theory: "man's basic nature is positive and good and only needs the correct environment and human warmth to be actualized" (Strasser & Randolph, 2004, p. 13). Such an example would be through Rosenberg's (2006) non-violent communication approach, where empathy and respecting others' needs supports a correct and warm environment. The literature suggests that conflicts occur in the workplace due to the tremendous diversity of humans. Therefore, "conflict is

a normal human process." (Martin et al., 2008, p.2). The common thread in all conflict is that if resolution is embraced, people can move forward.

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interviews, the co-researchers spoke to the experience of conflict in their workplaces. One co-researcher talked about experiencing double standards in conflict resolution within her healthcare facility. The policies and procedures in place were not adhered to. When she pointed this out, the policies and procedures were used against her. This co-researcher said:

> ...I know I haven't done anything wrong. I am not perfect and I know I'm not anywhere near perfect, but I'm still a person and I deserve better. There is a whole binder of policies and the healthcare agency that I work at has not fulfilled their side...

A second co-researcher explained how conflict was managed by the manager through frequent surveillance rather than talking to the co-researcher about her (the manager's) concerns. This is an example of intimidation rather than conflict management. This co-researcher said:

> ...about a year ago they hired somebody that is supposed to be the nurse in charge and kind of relates between the manager and the nursing staff...But anyway when she came… she decided to keep an eye on me. Every hour she would come down [to where I was working] thinking I couldn't have that many coffee breaks, every hour she would check on me. This went on for six months...

A common thread here (from the researcher's self-interpretation) is that managers, in a position of power, use policies or hiring as methods of controlling the co-researchers and

their colleagues, but this does not resolve or manage the conflict in the workplace. In fact, conflicts escalate. Managers seem to prioritize protecting themselves any way they can rather than seeking out a resolution to foster a win-win outcome (Strasser & Randolph, 2004).

Post*-Focusing *workshop interview data.

During the Post-*Focusing* interviews, the co-researchers shifted from their immediate experience of conflict and lack of conflict management to a broader perspective regarding their interpretation of management methods of dealing with conflict and the effects of this on the larger nursing culture. The first co-researcher talked about the effects of management skills on the nurses working under them (within the hierarchy of the organization). This co-researcher said:

> ...I think some of these issues that have arisen with management cause havoc to employees. I think they are trying to write human resource manuals on certain things and trying to be transparent. They say that there are all these things (policies); but when it boils down some of the nursing managers eat their young, they still get around that. (Even though there are agency policies and procedures that are developed to prevent workplace harassment and violence)...

A second co-researcher heard that she had made 'countless changes' for the better; however she also related that management had not treated her respectfully, nor had management wanted to resolve the conflict between her and them. She said:

> …it's interesting like the union gal that is helping now and the fellow that is on paternity leave both of them have said, "you have made unbelievable changes in the agency as far as the Human Resources policies go", and when something

> comes up, they deal with it right away and there has been countless changes…but still don't shut the barn door behind me. There has to be some accountability...

A third co-researcher had expanded her awareness from her own workplace violence experience to that of observing the manager's conflict management style with her colleagues. This co-researcher said:

> ...There is a few that I know she [the manager] has singled out to do that to [call into the manager's office], and some of them are feisty so she is a little bit more careful with them…most certainly there are some she has singled out...

Even when there was no environment of support, no positive approach and no warmth, these co-researchers managed to help the agency move forward. However, one co-researcher was disappointed that conflict resolution did not occur in her workplace. In fact, management refused to allow a conflict resolution professional to assist in the conflict. All three quotes point out that management and Human Resources did not make an effort to resolve or manage conflict; they seemed to remain in a self-protective mode. One co-researcher pointed out that being 'feisty' and taking a stand for oneself seemed to prevent unnecessary management involvement.

Embodied caring: Embodied caring for self and others.

Embodied Caring for Self and Others, within the context of this thesis research, means practicing caring habits toward one's own bodily needs and toward others' bodily needs, and contributing to the "well-being of self and others" (Hamington, 2004, p. 4). In nursing, Embodied Caring for Self and Others means engaging in life-giving and life-receiving therapeutic relationships which include responsiveness, loving, empathy and compassion, all of which support spiritual freedom (Watson, 2008). Caring is about

listening deeply with compassion and empathy to the wounded colleague while supporting a healing environment that invites all involved to be authentic, self-reflective and present to their own truthful experience (Conti-O'Hare, 2002; Madison, 2008).

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interviews, the co-researchers expressed caring for Self and others in the below quotes. The first co-researcher found that by working in two areas of nursing, she was not entrenched in the politics of either. Her awareness of this showed she was caring for Self. This co-researcher said: "...I guess what keeps me balanced is that I am working two areas: I do home care and acute care…Yeah the home care manager is really nice and that really helps...".

A second co-researcher took care of herself by not answering her phone when she was on stress leave. This set up a boundary between her and the healthcare agency that tended to phone her frequently. This co-researcher said: "When I was off on stress leave, there were shifts that needed to be filled…so the girls put in for it because I wasn't answering my phone...".

A third co-researcher developed several caring habits for herself. She chose to retire from her career earlier than she had planned because of her very traumatic workplace experience and that seemed for her to be a wise caring choice. This co-researcher said: "...I read, I knit, I really have excellent friends, and groups that I belong to. And they all know that I sort of left work earlier than I would have liked to; but I am happy...".

A fourth co-researcher talked about a spiritual caring habit. This co-researcher said: "...I do creative things to balance my life...".

When one is traumatized at one's workplace, self-care can lead down different healing paths. Such outlets as stress leave, creative endeavours, friendships and finding a kind and caring manager in the work environment are paths toward healing.

Post*-Focusing *workshop interview data.

Following their Post-*Focusing* interviews the co-researchers shifted from *recognizing that they needed to care for themselves* to caring for others as well. Caring for themselves helped them be better caring nurses for others.

One co-researcher spent a great deal of time and energy caring for others during his workplace violence experience; yet he recognized that he did not have self-care practices for himself. This shows awareness of his life situation and he realized that he needed to do more for himself. This co-researcher said: "...Nurses are taught how to talk to people and how to get issues out of people. But when it comes to yourself; how do you deal with it...".

A second co-researcher had learned to stay focused on her purpose as a nurse (a self-care practice), thereby recognizing her caring skills for the patients. This co-researcher said: "...I think I can stay quite focused on the fact that I am here for patient care and I am here to deliver quality care to the people that come into the system that are needing care...".

A third co-researcher talked about loving nursing and patients and how this was reciprocated. This indicates that this co-researcher was engaged in life-giving and life-receiving therapeutic relationships which had a tone of spiritual freedom in the midst of workplace violence.

> ...I give excellent care, and I just did what I loved and I got love back from them. I also have a lot of experience, so I could tell patients where to go or who to phone, provide resources. That made me feel really good; made me feel loved. I could then put it (my job) to rest and walk away...

At the Pre-*Focusing* interviews, two co-researchers spoke about needing to spend time and energy caring for themselves away from their workplace due to the intense situation. In their Post-*Focusing* interviews, the co-researchers were focused on caring for others, and for both a giving and receiving of care. As well, they still recognized that they needed to care for themselves. I, as the researcher, suggest that the co-researchers were very skilled at caring for their patients and other colleagues, yet perhaps not as skilled at caring for their wounded selves, although they were learning how to care for themselves. The comments during the Post-*Focusing* interview seemed to indicate that they were learning self-care habits and practices, which demonstrated a change.

Embodied caring: Safety for self and others.

Safety means feeling safe physically, psychologically, socially and spiritually. In a safe work environment nurses carry the sense that they will not be harmed or attacked (Lange, 2007; Nouwen, 1979; Scott Barss, 2010). Both safety and caring are deeply imbedded in the *Canadian Nurses Association Code of Ethics* (2008). The first nursing value consists of, “Providing Safe, Compassionate, Competent and Ethical Care” (CNA, 2008, p. 8).

Pre*-Focusing *workshop interview data.

During the Pre-*Focusing* interviews the co-researchers talked about the lack of trust, lack of communication and lack of feeling safe from management and other colleagues in their nursing practice settings.

One co-researcher talked about having no trust or safety in his nursing practice setting. His description suggested that he was working in an environment that was not safe for him to work in. This co-researcher said: "...Yeah the trust level with the facility is zilch and maybe it would have been different if they would have reprimanded her or done something to protect me…none of that came through, in fact it was the opposite...".

A second co-researcher reported that there were not enough staff members to maintain patient safety and in one instance, there was no nurse to accompany a patient to a more appropriate healthcare facility, which violated that patient's safety. This co-researcher said:

> …anyways I found out when we were going to send the patient off to the city, I just assumed that I was going to look at the call-in list, because we do have EMTs out there but we don't always have EMTs available, sometimes it is just first responders; so that day it just happened that it was just EMTs. EMTs can manage an IV but not IV meds; so then you have to send a nurse. So I go to the call-in list, there is none, it's gone. I am saying to the girls I work with, what happened to the call-in list? Oh that got stopped about three weeks ago…We are at the point where we are ready in ten minutes to send this person and we were already bare-bone staff...

A third co-researcher explained how unsafe it could be for her when she was expecting safety practice to be followed. This co-researcher said:

> ...there was another time where the practical nurse gave the clerk an order to tell me to do something…But I told the clerk that I cannot take an order from a practical nurse or a Registered Nurse. This type of order needs to come from a doctor; it has to be verbal or a written order…So anyway the clerk comes back with a written order and she slams it on the desk and says, 'yeah they are not very happy with you' (the co-researcher) …

It is unfortunate that these co-researchers did not experience safety for themselves or their patients. This is very alarming as it has a deleterious effect on the patients as well as the co-researchers. In fact, when the co-researchers attempted to provide safety for the patients, they were met with hostility and became entangled in intercollegial conflict. Further there seemed to be no way to resolve the situation safely for themselves or for the patients.

Post*-Focusing *workshop interview data.

Within this theme, Embodied Caring, and the sub-theme, Safety for Self and Others, the co-researchers demonstrated a shift from experiencing a lack of safety in their practice settings to a more optimistic experience of safety for themselves and patients in their workplaces.

One co-researcher, as a manager, put a stop to a potential intercollegial workplace violence situation by saying there was no place in this facility for bullying new staff. This co-researcher said:

> ...I have not had to do any conflict resolution yet; but I think it has to do with the way I run things; if I had to I would; I wouldn't be opposed to it. It was close between a longer term staff and a shorter term staff and there was an issue that continued to rise…the longer term staff was putting her foot down on the other one and I did the scheduling thing at that point and I talked to that long term staff and I said, You can't be doing that, there is no place for that here....

A second co-researcher was now modifying her manager's workplace practices by questioning the manager and focusing on all concerns including patient complaints. She said:

> ...Patients take things to me that I took to the manager and she said that unless the patient complains directly to me, I can't do anything. So why do we have a policy on near misses?…Our patients that come here, even the families that come literally are fighting for their lives and the last thing they want to do is put energy into something like this – make that big complaint...

A third co-researcher saw a bigger picture and suggested that nurses needed to learn to be politically active to achieve better care for the patients. This co-researcher said: "...It would be safer if nursing were politically active and advocated for higher quality of healthcare...".

A fourth co-researcher also responded within the bigger picture and acknowledged that she advocated for the patients, despite what her colleagues thought and say. This co-researcher said: "...Yes, I am a very strong patient advocate...".

Embodied caring summary.

As the researcher, I come from a 'needs place', which theory posits that all behaviour is motivated by a person's needs, including: "autonomy, celebration, integrity (and safety), interdependence, play, spiritual communion, and physical nurturance" (Rosenberg, 2006, pp. 17 – 18). Embodied caring answers all these needs and requires a safe, supportive, warm environment (Strasser & Randolph, 2004; Watson, 2008). I am concerned about nursing practice settings becoming war zones, with very little regard for patient, family and staff safety. Within the work place, conflict resolution/management is not practiced and policies and procedures are not being followed. Further, according to these co-researchers, reported 'near misses' are not being investigated. It seems that the co-researchers' physical, psychological, social and spiritual needs within their nursing practice settings were not being met. They were wounded physically (the bodily felt discomfort of being hurt and wounded), psychologically (through conflict and politics), socially (by being abused for upholding their values – caring and safety), and spiritually (through not being respected for advocating for the patient – a nursing value).

Chapter Eight: Implications

This section will present how the above research and findings impacted the co-researchers and me as the researcher. One of the direct influences of the data and analysis on me was a modification of Heidegger's *Five Facets of a Human Being* to the *Six Facets of a Human Being Assessment* (Figure 3, p. 142). There are also indirect influences that need to be discussed: for the healthcare organizations; the broader *Focusing* community; and the counselling and psychotherapy community at large. As well, I will incorporate the literature in the discussion of implications. Possible future research for workplace violence and *Focusing* will also be outlined.

Implications for the Co-Researchers

Listening deeply to interviews produced evidence that the intercollegial workplace violence experienced by these five co-researchers (nurses) had caused significant trauma and wounding. Clearly, the co-researchers experienced a number of negative and raw feelings, including: shame; fear of being unsafe; abuse related affects; feeling trapped; and vulnerability. All of these experiences and resultant feelings caused immense suffering. For example, shame appeared to be a pervasive experience for the co-researchers and was discussed three different times through the thesis in: 1) the Pre-Metaphor phase; 2) the Workplace Violence theme and sub-theme Shaming Behaviours; and 3) the Embodied Spirituality theme and sub-theme Shame and Suffering. At the time of the research, the co-researchers appeared to be in the transformational process (healing their wounds from the trauma) even though they had transcended aspects of their experience through the research project. For example, they had distanced themselves from the raw emotion and were able to reflect on the reasons for the abuse. They created,

Figure 3. The Six Facets of a Human Being Assessment

Is embodied in time – humans are in process over time moment to moment

- The past is in one's body influencing and remoulding the present and the future
- What are the distressing life situations and strengths related to the now situation?

Is embodied:

- Loss of some part of self
- Suffering
- We experience, live, respond and move from our bodies
- Where in their body do they experience their potential felt sense of their life situation?

Is embodied self-interpreting:

- Metaphor pre- and post-*Focusing* workshop/counselling session
- Self-interpreting one's lived experience is not reflective or non-cognitive
- Dilemmas of existence such as suffering
- What possibilities and choices are available for the client being in his/her world?

Is thrust/thrown/situated /born in an *a priori* world:

- A person is situated in existing relationships, linguistic skills, practices and traditions, embedded in the culture (the world is beforehand).
- What are the metaphors of the persons being in their world?
- What are the qualities of the person's relationships in the genogram?

Is embodied caring:

- Values such as interconnectedness and independence, ethical caring, social morality, commitment to self and others and valuing others
- What matters to the person; what are their care practices?

Is embodied spirituality:

- Spiritual practices and processes
- Focusing as a spiritual intervention
- Expansion of the authentic self
- Spiritual freedom from vulnerability
- Spiritual needs?
- What are the spiritual practices of a person or lack of?

maintained and enforced psychological boundaries, while remaining true to their own values and caring practices.

It is interesting that all five co-researchers came from different nursing practice settings, yet experienced similar intercollegial workplace violence. This would suggest that intercollegial workplace violence has similar components which could make such violence easier to identify and to resolve. It might also be helpful for victims to know that their emotional and bodily reactions are normal and similar for all. Recognizing the similarity of emotional and bodily reactions may be healing in itself which is considered part of the *Focusing* experience (Gendlin, 2007; Hinterkopf, 1998; McMahon, 1993).

Implications for Myself Personally and Professionally

For myself, facilitating *Focusing* and spiritual practices and processes is highly valued and benefits my expanding authentic Self. I saw how *Focusing* and spiritual practices and processes worked well together during this research. I also discovered how Heidegger's *Five Facets of a Human Being* (Leonard, 1994) provided an additional theoretical framework for the intervention of *Focusing* within this research. These five facets are:

1. That the human's experience is of having an *a priori* world (the nursing culture, language, history, metaphors): all of these things are already happening before the nurse is thrown (hired) into a nursing practice setting with its culture, its own language, relationships and practices.
2. That the human being cares about things that matter, including feelings, values and other things we care about: what distresses nurses, what activities/projects nurses pursue, such as advocating for the patient or

ethical/moral behaviour, and our underlying needs and desires; therefore nurses need to make a stand for themselves regarding things that we care about (quality patient care).

3. That the human being is self-interpreting in a non-cognitive and non-theoretical way; we are always interpreting what is happening to us: we are constituted by our self-interpretation of our lived experience; meaning nurses are involved participants in their own understanding of their lived experiences and in the care practices they provide to patients.
4. That the human being is embodied: the body is the living centre that provides existential possibilities: our bodies provide the vessels for concrete action for Self in a meaningful world; nursing assists both the patients and themselves in restoring embodiment and wholeness.
5. That the human being is a being in time: from the 'having-been-ness' (the past) to a transition period of now (or the present) and moving into the future: the present is influenced by both the past and the present. Nurses are interested in patients' past history so that they can assist them in moving forward to a better future; and nurses are thrown into a particular cultural situation and time with embodied practices and meanings.

These five facets resonate with the *Focusing* way of moving forward from the person's life challenge (such as intercollegial workplace violence) to a more optimistic future. *Focusing* invites the participant to pay attention to his/her embodied wisdom, discomforts and the body's needs and desires (Gendlin, 2003a, 2007). Further, these five facets

assisted me in interpreting the co-researchers' data and with thematically analyzing the Pre- and Post-*Focusing* workshop interviews.

I have added a sixth facet – Embodied Spirituality – to Heidegger's Five Facets (Heidegger, 2010; Leonard, 1994). My decision to develop and include Embodied Spirituality is practical and grounded. I can and do use it in my nursing counselling practice and when I am teaching the intervention *Focusing*. The *Six Facets of a Human Being Assessment* helps me gain an understanding of clients and assists with my client interpretation and the learners' lived experiences as they share them with me. The following is a brief description of the *Six Facets of a Human Being Assessment* that emerged from my thesis experience:

Human being is having an *a priori* world: a person is thrust/thrown/born/situated into the world of relationships, language skills, practices and traditions coming out of the existing culture and its history/era. Our world is there beforehand with its everyday practices and activities (embedded in our culture), and we tend to be oblivious to this already given world. As a nurse therapist, I will be listening for the metaphoric language as this is one way that clients call things from their world into being (Leonard, 1994). The psychological self develops from an *a priori* world – another way for me to assess the client. The use of the genogram works well in this facet as I can use a family history with its various qualities of relationships, and its familiar practices and traditions to provide the context surrounding the clients, 'being' in their world.

Human being is embodied caring: includes caring for self and others. As Hamington (2004) states, "...embodied care reinforces interconnection by starting with our shared embodiment" (p. 127). The underlying values in this facet are

interconnectedness and independence, ethical caring, social morality, commitment to the growth of Self and others, and active participation (listening and encouraging) in valuing each other. For me, embodied caring involves things that matter, are of value to the clients, including what distresses them, and what activities and projects they pursue. What are the clients' care practices, rituals, traditions and ethics for themselves? As a therapist I actively listen for the client's self-care practices. Included in this facet is a determination of what motivates the clients, what are the underlying feelings, emotions and mood states: love, hate, guilt, shame, fear, sadness, shame, happiness, anxiety and/or depression, etc. Most important for me is to establish what are the underlying needs and desires that motivate the client's behaviour. These caring practices, traditions, rituals and behaviours will be different for each client depending on his/her an *a priori* (cultural) situation.

Human being is embodied self-interpreting: keeping in mind the clients' *a priori* situation, and their embodied caring values and things that matter. I will listen for the clients' self-interpretation of their significant life situations. Self-interpretations of the clients' beingness are non-reflective or non-cognitive. We are constituted in our self-interpretation (understandings of our world). Every experience is understood from the background of the client's *a priori* world – through his/her culture and linguistic tradition. Possibilities and choices will flow from the client's *a priori* world, his/her existing life situation and his/her self-interpretations. This is important for me to know as a therapist.

Human being is embodied: humans are embodied rather than having a body. Humans experience and self-interpret with their bodies or as Madison (2010) states, "We

feel our life events because our bodies instantly interact experientially with the whole situation" (p.192), whether we are fully aware of the experience or not. We experience, live, respond and move from our bodies. When clients or *Focusing* learners are in my company, I wonder where in their body they experience their potential felt sense of their life situation in the moment. I am also curious about whether clients and learners can access their felt sense in their body. We have common body perceptual capabilities and it is our bodies that interpret our life situations and interact with our environments. Further, humans have body intelligence, and as a therapist I encourage and invite the clients to listen to their embodied intelligence and wisdom. As a nurse therapist, I listen to and observe the client's ability and willingness to connect with his/her bodily discomforts, wisdom, intelligence, and needs. It is our living in our bodies that generates concrete action in the world as we interpret our life events. Therefore, I listen for the clients' resiliency, Self-mastery, and Self-efficacy skills.

Human being is embodied in time: Humans live by the clock, day and night time, seasons, and by a calendar. Paying attention to the clients' bodily experience in the present (the now) brings up familiar past experiences. In other words, any feelings or sensations concretely felt in the human body will also bring a calendar and history from the past life situations into the present life situation, together with the idea of moving forward into the future. Humans innately want to explore and remould their past painful experiences in the present and move forward in a freer way (Todres, 2007). As a counsellor, I want to learn about their past painful experiences and have them create a metaphor to represent their current life situation. It is through a client's metaphor and storytelling that as a therapist I can observe the remoulding of the past and present

situation into a more optimistic future (much like in the research project). I am also listening for, "...what does it mean to *be* a person..." (Leonard, 1994, p. 46) in the past, present and future, and observing the subtle and not-so-subtle changes in the client.

Human being is embodied spirituality: humans stay grounded, centred and heal through their own chosen spiritual practices and processes (Hinterkopf, 1998). Embodied spirituality means listening to one's body's wisdom and intelligence and connecting to one's larger/higher power to find significant meaning and substance. Spiritual practices include religious and/or transformational and transcendent experiences, that bring the client through a process to a clarity of lived experience no matter how much suffering is involved.

Humans have access to and can expand their authentic spiritual Self (as distinct from their psychological self that is formed through relational experiences) through their embodied spirituality (Todres, 2007). The spiritual Self involves being free from a self that has been defined through relationships and this spiritual freedom is fertilized from the existential experience of being vulnerable such as in existential suffering. The bio-spirituality *Focusing* community suggests there is a connector between humans and the larger body (i.e. larger power/God/Divine/Transcendent), which can be recognized as the Self (Campbell & McMahon, 1997; McMahon, 1993) or the spiritual Self.

For spiritual health, one's values must be embodied and carried forward (Hinterkopf, 1998) in life in order for transformation and transcendence to occur. As well, for spiritual health it is important to connect with Self, and one's larger body/power/God/Transcendent, and to become more conscious as one reflects on life experiences (Conti-O'Hare, 2002; Scott Barss, 2010). In the nursing community, it is

considered unsafe not to address or assess the clients' spiritual health and practices or lack of. As a nurse therapist, I listen for and closely assess signs of spiritual health, spiritual distress, spiritual needs and the clients' preferred spiritual practices. Then I can facilitate a spiritual process in terms of the clients' embodied spirituality.

The Intervention *Focusing* as a Spiritual Intervention

Focusing is a deep self-reflective process and a practice for listening to the body's inner wisdom and intelligence. Intercollegial workplace violence causes a great deal of bodily discomfort worthy of deep listening and self-reflection, and therefore provides a fertile ground for humans to become more Self-knowing.

Focusing practitioners realize that when they are *Focusing* they bring an *a priori* facet into the *Focusing* session: their era, history, culture and linguistic practices. An example would be when the co-researchers where thrown into their nursing culture of normalized workplace violence. Such practices give rise to *Focusing* possibilities in terms of dealing with such a workplace situation. Focusers will focus on things that they care about and will discover more things that will matter during the *Focusing* process, hence clarifying their values. This second embodied caring facet was illustrated by the co-researchers caring for others and Self. Hamington (2004) suggested that embodied caring enhances human interconnection because of our shared embodiment. The underlying values in the co-researchers' quotes presented throughout this thesis were: interconnectedness and independence; ethical caring; social morality; commitment to the growth of Self and others; and active participation (listening and encouraging). Distinct examples of the third facet embodied self-interpreting were found in both the Pre- and Post-*Focusing* workshop metaphors (e.g.: "...being like a three-legged fox, that could just

drift down the river and land somewhere where it's by itself so it could recuperate...it's just a kind of place to lick wounds..."). The fourth facet that humans are embodied means that humans experience and interpret life experiences through their bodies such as existential-suffering (Madison, 2010).

Humans are embodied in time (the fifth facet). We live by the clock, day and night cycles, seasons, and a calendar. We will bring our calendar into the *Focusing* session directing attention to our experience in the moment. In *Focusing*, "...the body as 'unfolding process' bring[s] in one's past…" and "...remould[s] by the present moment" (Madison, 2010, p.193) and yearns to move (carry) forward our life. It seemed that *Focusing* helped the co-researchers move forward from the experience of workplace violence trauma and wounding toward a transformational and transcendent experience. As Gendlin (2003a) suggests *Focusing* "offers phenomenological access to how the body interacts with our situations moment to moment" (Madison, 2010, p. 193). In this research project, the co-researchers reflected on their bodily experiences of the impact of workplace violence both before and after a *Focusing* workshop. This enabled them to stay with their bodily experience in the present moment and provide the researcher a powerful example of how a human being is embodied in time.

As a researcher, I suggest that *Focusing* is a spiritual practice and process and as such should include the sixth facet embodied spirituality. Through the experience of this research project using *Focusing* as an intervention, I suggest that *Focusing* supported the co-researchers in the following ways:

a) By re-embodying their own personal values (kindness, advocacy, creativity; speaking one's truth, loving the patients);

b) By assisting them with Self-efficacy (managing every changing life-circumstance), and Self-mastery (making a stand for one's Self), and drawing on their Self-resiliency (through humour); and

c) By transforming and transcending their traumatic, wounding workplace violence experience, thereby becoming part of their larger authentic Self.

This discovery has inspired me to develop the sixth facet of human being – embodied spirituality.

In summary, there is a great deal of correspondence between the facets of a human being (Leonard, 1994) and the assumptions behind *Focusing*, and these similarities appeared in the context of workplace violence for nurses. Any bodily feelings or sensations are concretely felt in the body and humans will bring their calendar and history from the past into the present with the idea of moving forward into the future. Humans are thrust/thrown into workplace environments and do not have a choice as to their co-workers. Their workplace colleagues will also bring their pasts into the workplace as they all individually, and perhaps collectively, move forward. Humans are self-interpreting, self-reflecting and sentient beings and need to create meaning in their lives. The present research has illustrated that nurse beings care about things that matter such as: patient care, ethical behaviour, self-care, collegiality, etc. Adding to that, all human behaviour is motivated by needs such as: autonomy (power), interdependence (freedom), celebration, integrity (safety), play (fun), physical nurturance, rest and spiritual communion (Gossen & Anderson, 1995; Rosenberg, 2006). All of this was part of the co-researchers' self-reflecting, transformational, transcending and self-interpreting processes. Self-reflection occurred through spiritual processes such as the researcher

listening to their stories (the power of storytelling) and the co-researchers experiencing the *Focusing* workshop. Both processes were self-reflecting and involved all researchers listening closely and having relationships with their experiences and their larger body/larger Self (McMahon, 1993), rather than shutting off experiences or reactions (Gendlin, 1964b, 1968, 1984; Madison, 2010; Stone, 2004).

Implications for the Researcher's Nursing/Counselling Practice

The intervention *Focusing* demonstrated its helpfulness and appropriateness as a method of self-care and self-reflection, as well as assisting with significant problem situations such as suffering. *Focusing* does not expect the participant to do certain things, nor does it force or push or demand that the participant follow a formula to heal or be more functional. *Focusing* invites the participant, at his or her own pace, to explore bodily experiences related to trauma; therefore healing unfolded according to each co-researcher's body wisdom. Clearly, safety is an important aspect of the intervention *Focusing*. Safety for the patient is an important value carried by the nursing community, and it was embodied throughout this research project, as it is in the researcher's counselling sessions and in her *Focusing* workshops.

After using the Pre- and Post-Metaphor inquiry with the co-researchers, the researcher saw the value in using creative and gentle curiosity with the clients in her therapeutic counselling sessions. In fact, asking a client to come up with a metaphor has been very beneficial for both the client and the counsellor, because "imagination creates metaphors and metaphors transcend words and gives the researcher 'an image-picture'" (Gendlin, 1985, p. 384).

Another important aspect of the researcher's counselling practice is the facilitation of spiritual practices and processes, which are now embodied in the *Six Facets of a Human Being Assessment*. This is the foundation of my practice. The nursing community takes a serious approach to spiritual care in nursing practice settings and suggests that not providing spiritual care to patients is considered unsafe (Scott Barss, 2010). When the co-researchers expressed dispirited feelings of helplessness, hopelessness and powerlessness, the Post-Metaphor and post-interview findings suggested that *Focusing* was part of the healing process. I noted that the co-researchers used spiritual practices such as creativity, humour, resiliency and kindness. They seemed to rely on their own values and made a stand for themselves. They were involved in self-reflecting, storytelling and authenticity to maintain some sense of Self. I suggest that the co-researchers' ability to engage in spiritual practices and processes such as *Focusing* assisted them in retrieving their authentic Self and perhaps helped them expand their true Self. The co-researchers had the courage to struggle and suffer until they gained 'Self-mastery' (Madison, 2011) and experienced spiritual freedom from their intense vulnerability (Todres, 2007). Perhaps suffering is a beginning of a spiritual process.

Implications for Healthcare Organizations

It can be seen clearly from the results of this research project that intercollegial violence: a) causes stress and more intercollegial violence; b) affects patient care; c) is costly in terms of stress leave, losing experienced nurses from the practice settings, nurses going part time; and d) provokes the healthcare worker not to be as productive as he/she copes with the stress of a hostile environment. For example, two co-researchers left the nursing practice setting (one left nursing permanently), two co-researchers went

on stress leave, and one went part time. Organizations must spend money, human resources and time to orientate new nurses in conflict resolution and sick time scheduling. Pearson and Porath (2009) discuss the costs of bad behaviour in the healthcare settings. These authors actually 'did the math' on financial costs in one healthcare organization due to incivility, and estimated a phenomenal cost of $70,911,390.44 per year for a specific healthcare organization. In addition, Pearson and Porath (2009) discovered that incivility in healthcare teams causes serious patient care errors and sometimes death. Incivility coming from outside the team will contaminate the team's performance and productivity, as the team members will spend a considerable amount of time and energy caring for the team members who have been mistreated. The same may be expected for incivility within a team. If the team works closely, members will start mimicking one another's bad behaviour. Pearson and Porath (2009) stated, "Most offenders seem unaware of just how damaging or costly incivility is" (p.110). Offenders seem to lack the knowledge that their targets will either directly or indirectly get even. Offenders can develop a reputation that can and will be shared from one workplace to another and reputations tend to follow the offender.

Only one co-researcher sought out mediation for a workplace conflict situation. For the rest, there seemed to be no avenue or support for conflict resolution/management in their workplaces. The one nurse who did seek and initiate conflict resolution on her own was successful and gained respect from her colleagues, which speaks to the benefits of such a practice.

As the researcher, I return to the literature review and di Martino's (2003) World Health Organization working paper for data and information related to workplace stress and violence in which he forcefully states,

> Stress and violence are widespread in the health sector. Doctors, nurses and social workers are all high on the list of occupations with serious stress levels while violence in the health sector constitutes almost a quarter of all violence at work. (p. 6)

Stress and workplace violence in the healthcare sector is such a concern that in the year 2000, a group of organizations, including the International Labour Office, World Health Organization, International Counsel of Nurses, and Public Services International, collaborated to develop reputable policies and hands on approaches for preventing and eliminating violence in the healthcare sector. Nurses should not have to fear for their life and livelihood. They should not have to feel ashamed, abused, belittled, demeaned or insignificant for being human. They should not need to have recourse to a metaphor such as a bull jumping the fence harassing the cows or a three-legged fox drifting down the river wanting to be alone to lick its wounds. These co-researchers (according to my interpreting-Self) were very poorly treated because they were honest, voiced their concerns, wanted a better nursing practice setting with high-quality care, wanted to advocate for the patient, wanted to be kind to the patients and their families and wanted a win-win dialogue so that everyone might walk away with respect and dignity.

According to di Martino (2003), stress in the workplace enhances the possibility of workplace violence and any type of workplace violence will increase one's stress levels and "In practically all cases violence, including minor acts, generates distress in

the victims with long-lasting, deleterious effects on their health" (di Martino, 2003, p. 6). Extensive restructuring, revamping, downsizing, increasing workloads, and higher expectations of the healthcare worker also increase stress, therefore workplace violence. The healthcare providers, such as nurses, will bear the brunt of all of this.

Stress and violence are not just individual challenges; rather they represent structural problems entrenched in the culture and have social, organizational and economic factors (di Martino, 2003). Three approaches discussed by di Martino to workplace violence include: a) prevention - eliminating stress and violence in the workplace rather than just the individual; b) participation - such as "...social dialogue in defusing situations of work-related stress and violence" (di Martino, 2003, p. 26); and c) the "High Road Approach" (di Martino, 2003, p. 26) using best practices that are concrete, practical and immediate. This developmental response involves the workers' well-being and their health and safety as integral parts of the workplace's growth and enterprise.

Tinsley and France (2004) conducted a hermeneutic phenomenological assessment regarding the reasons for nurses leaving their active practice and found that: a) nurses love nursing; b) nurses experience suffering due to burn out and abuse related to oppression; and c) nurses long to recapture their love for nursing. What these authors call oppression is related to what this research project refers to as workplace violence. Oppression included: a) intercollegial shaming behaviours; b) feeling bad for not giving better care due to burn out; c) lack of intercollegial support; d) being controlled by higher status external forces; and e) feeling trapped with nowhere else to work. The implication for this research project, similar to the work of Tinsley and Frances (2004), is that

healthcare workers in all areas of the healthcare sector need to foster a culture of caring. As well, managers and human resources would benefit from recognizing that workplace oppression, hostility, incivility, bad behaviour, or as the researcher states, 'workplace violence', all cause suffering. Suffering causes a person to perceive that there is a threat to the integrity and intactness of one's Self. One potentially powerful response would be for managers and human resource officials to gain training and skills for both reducing the potential for workplace violence and for responding to staff in a helpful and sympathetic manner to reduce the potential harm from workplace violence.

Implications for the *Focusing* Community and the Counselling and Psychology Community at Large

The findings from the raw data appear to demonstrate that there is a natural or organic movement within an individual from traumatization to human growth, evidenced by skill development and resiliency building that was noticed in the co-researchers. Without any cueing from the Post-*Focusing* interviewers (researcher-nurse colleagues), two out of the five co-researchers stated that the *Focusing* workshop had been helpful both professionally and personally (please see Appendix C for questions asked during the Post-*Focusing* interview). One co-researcher stated that it "helped me to realize to relax a bit more, to be in tune with myself". The other co-researcher stated, "After the *Focusing* workshop …you start to learn new tools or new ways to look inside yourself and deal with your feelings". These two quotes suggest that each got closer to his/her authentic Self (as described earlier in the text). The other three co-researchers demonstrated healing of their psychic wounds from their traumatic workplace violence experiences. For

example, one indicated that “I could stand up in front of a mike, in front of a crowd of people and tell people what I went through. I wouldn’t feel as intimidated”.

To date (2010), I am not aware of any research on *Focusing* as an intervention specifically for anyone experiencing violence in any workplace. Yet workplace violence is a very serious concern globally (di Martino, 2003). Following the intervention *Focusing*, the co-researchers demonstrated healing and transformation. They became more in tune with themselves, became more Self- aware, gained wisdom, enhanced their resiliency, Self-efficacy, and Self-mastery skills, and developed a larger capacity to deal with personal and professional life situations. The results from this research project clearly indicated that *Focusing* is a viable and successful intervention for people struggling with feelings of shame, suffering and trauma. This research adds to the already large body of research supporting *Focusing* as a useful intervention for various challenges.

Implications for the Research Project

It appears that based on this descriptive study, which was appropriate for a hermeneutic/interpretive phenomenology research design, *Focusing* as an intervention holds real potential for helping people who have experienced or are experiencing intercollegial workplace violence or any workplace violence. However, to those from a research paradigm that wishes definitively to ascribe causality, I must declare that this research is a one-group pre-test/post-test design and so is without a control or comparison group (Mertens, 2010). The caution typically sounded for this paradigm is that the design is vulnerable to threats of maturation and history, meaning that the co-researchers may have experienced maturational changes or external events that could have influenced the

observed changes. Some researchers have stated that the current research design could be justified since the knowledge, behaviour and attitudes (such as resolving or relieving suffering) are unlikely to have changed without such a specific intervention (Borg & Gall, 1989).

Future research could consider a design involving an experimental approach referred to as a “pretest-posttest control group design” (Mertens, 2010, p. 134). This design would involve three phases: a) a pre-interview, an intervention and post-interview (R O X O); b) a wait list with a pre-interview, *no intervention*, and post-interview (R O O); and c) an intervention and semi-structured interview (X O).

I am also interested in how patients, families and friends experience workplace violence vicariously in the healthcare settings when witnessing intercollegial violence or being pulled into such situations. This would be a larger study and would include the invitation for the participants to learn the intervention *Focusing*.

Chapter Nine: Summary& Conclusions

Summary

The literature review reflected an enormous concern about workplace violence in the healthcare sector. Globally, up to twenty-five percent of workplace violence occurs in the healthcare sector (di Martino, 2003). Of that twenty-five percent, nurses, physicians and social workers incur the brunt of workplace violence. WHO, as well as many healthcare sector organizations and regulatory bodies, discuss extensively workplace violence in nursing practice settings, including: a) how stress and violence are related; b) recommendations and guidelines to improve and enhance healthy workplace settings; c) the effects on the individual and the healthcare team from workplace violence; d) the benefits of supporting a healthy workplace; and e) the responsibility of the individual and of the various levels of management, as well as the importance of education settings and regulatory bodies. In other words, responsibility for preventing and intervening with workplace violence belongs to everyone in the practice settings.

As the researcher, I provided the intervention *Focusing* (at an individual level) as a method of self-care, self-reflection and self-discovery, for the nurses who incurred wounding from traumatic intercollegial workplace violence. Five courageous co-researchers journeyed with me through the research process and through three stages of a healing-transcending process: a) the Pre-*Focusing* Metaphoric and Pre-*Focusing* Workshop interview; b) participating in the *Focusing* workshop (as the intervention) and c) the Post-*Focusing* Metaphoric and Post-*Focusing* interview. Five Pre-*Focusing* metaphoric themes emerged from the data (as shown in Figure 1, p. 77). These were: 1) Shame; 2) Fear of Being Unsafe; 3) Abuse; 4) Trapped or Entrapment; and 5) Vulnerability. As well, five Post-*Focusing* metaphoric themes emerged from the data (as

shown in Figure 1, p.77). These were: 1) Healing Process Emerging; 2) Liberated Feelings; 3) Establishing Firm Boundaries; 4) Be True to Myself (Self); and 5) Fresh, Creative, Spiritual and Hopeful Way of Being. With the thematizing, five Pre- and Post-Interview themes emerged from the data (as shown in Figure 2, p. 80): 1) Workplace Violence; 2) Poor Healthcare; 3) Resiliency; 4) Embodied Spirituality; and 5) Embodied Caring.

The most significant changes noted from the data were in the Metaphoric phase of the research. The metaphors changed significantly from the Pre-*Focusing* interview to the Post-*Focusing* interview, with the Post-Metaphoric theme, 'Fresh, Creative, Spiritual and Hopeful Way of Being' surfacing strongly with descriptions of the depth of healing that seemed to happen. I suggest to the reader that Resiliency, Embodied Spirituality and Poor Healthcare themes showed significant changes towards healing, as there seemed in the Post-*Focusing* interview to be an expansion of the co-researchers' authentic Self. It was difficult to judge or measure the themes in terms of changing or shifting from a place of woundedness to a place of healing. However, I suggest that within the themes Workplace Violence and Embodied Caring there was not as much healing demonstrated as in the other three themes, possibly because the co-researchers did not receive much support from their environment in terms of resolution or healing. Embodied Caring, involving the co-researchers, caring about themselves and the patients, represents a high expectation when the nurse is already struggling to stay afloat in a hostile practice setting.

The *Six Facets of a Human Being Assessment* (Figure 3, p. 142) was developed as I interpreted the co-researchers' embodied self-interpretations of their workplace violence experiences, which I now use as a counselling assessment tool. Embodied Spirituality

with spiritual practices and processes were crystallized for the researcher as the foundation for her nursing counselling practice and proved to be primary pathways in the co-researchers' healing processes.

The methodology – hermeneutic/interpretive phenomenology – shaped the research project, leading the researcher to reflect deeply and help analyze the co-researchers' self-interpretations of their workplace violence traumas and their healing processes.

The implications from this research project were many and addressed: a) the co-researchers' well-being and the need for healthcare workers to foster a culture of caring; b) my personal and professional life – specifically, that spiritual practices and processes are highly valued for me as a researcher, as a nurse counsellor and as a human "becoming"; c) the benefits of the intervention *Focusing* for individuals experiencing workplace violence; d) the healthcare organizations, as the costs of workplace violence are extensive and immense both in human cost and in dollar cost; e) the *Focusing* community and the counselling and psychology community at large, as the intervention *Focusing* influenced the researchers' healing processes and *Focusing* could be an integral approach to assisting individuals with workplace trauma; and f) the research project itself, while remaining true to its constructivist research paradigm (Mertens, 2010), this project acknowledged the possibility for future research using an experimental approach to further investigate *Focusing* as an intervention.

Conclusion

This research project, the co-researchers (nurse colleagues) and its process touched me deeply – so deeply that the next few paragraphs will only give a brief sketch of my sense of what has been implied here.

I am both concerned and hopeful after journeying with the exceptionally courageous, brave, wise human beings (the co-researchers), who taught me about integrity, resiliency, Self-efficacy, kindness, compassion and the human beingness of the individual. Humans live in a world/era of dislocation, fragmentation and violence and this dislocation, fragmentation and violence is echoed in the workplace and particularly in nursing practice settings. We are at the beginning stage of how to reconnect with each other after conflict and trauma has occurred. We are just beginning to learn how to repair broken relationships, be inclusive with each other, community-build and develop a culture of caring. I suggest that we need more than a culture of caring.

North Americans live in a culture of shame and blame (Brown, 2007), fear (Bartholomew, 2006), oppression and violence (McMahon, 1993). These raw feelings are very present in the healthcare sector. I suggest to the nursing community that we embrace an embodied respectful approach, human-to-human; I suggest that we develop, maintain and enhance collegial relationships. After reading about the Ubuntu philosophy (Mulaudzi, Libster, & Salaminah Phiri, 2009) as it is applied in an African nursing culture, I want to add to the embodied respectful approach. I suggest we support a community that welcomes new and seasoned nurses entering our professional practice settings. The Ubuntu nursing communities practice diplomacy, mentoring, nourishing the collegial relationship, participatory leadership, solidarity, inclusiveness, and caring; all of

which I encourage the reader to consider. Everyone is on equal footing and has something to offer the nursing profession, the nursing collegiality and the practice settings. Another key element to the culture of caring would be that, when a conflict occurs, the nurses embrace the conflict as an opportunity to move forward individually and collectively. I suggest, with the notion of embracing conflict, that there also be a culture of repair and restitution, meaning that there are interventions in place to repair injured relationships and that, if necessary, the injurer and the injured discuss how to unfold a restitution process that repairs the relationship (Gossen & Anderson, 1995). Sometimes an apology is needed. Sometimes more than an apology is needed, such as defining the nature of the relationship with psychological boundaries, or accessing other interventions such as mediation.

I am encouraged by the intervention *Focusing* as a self-discovery, self-reflection and self-care process, which by its philosophy invites the individual to have a respectful, compassionate, and caring attitude towards all that emerges from listening to one's bodily wisdom. The practice of *Focusing* would fit with the invitation for nurses to develop a culture of caring.

I was also pleased to discover that nursing is embracing the notion of an embodied caring science (Sakalys, 2006; Watson, 2008). Nursing prides itself in providing professional, relational, knowledgeable caring to the patient (Benner, Sutphen, Leonard, & Day, 2010). Perhaps now is the time for nursing to embody caring with each other – human-to-human. Sakalys (2006) is resonant with my existential hermeneutic awareness that nurses bridge the practices of caring for the patient's body and the

patient's personhood. For me, the body and personhood are one; body and Self are not separate.

The hermeneutic/phenomenological interpretive body-based research approach was congruent with the *Focusing* intervention and with my own personal embodied self-interpretation of the co-researchers' metaphoric and interview language. This qualitative approach to interpreting the meanings from the co-researchers' spoken data required a to-and-fro movement between their words and my felt sensing of the lived experience of their workplace violence traumas. The intervention of *Focusing* invited the co-researchers to listen, Self-reflect and Self-discover their bodies' wisdom so that their bodies' wisdom could move (carry) them forward (heal, transform and/or transcend their life situations).

Finally, I was in awe of the co-researchers' Self-mastery, Self-discovery, and expanded Self as they voiced and self-interpreted their workplace violence experiences; they listened to their body's wisdom. Truly, they are role models for me.

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Appendix A

Advertisement

Have You Experienced Workplace Violence in Your Practice Setting?

I am a student in the Master of Arts in Pastoral Psychology and Counselling at St. Stephen's College in Edmonton, Alberta, University of Alberta Campus. I am inviting nurses who have experienced workplace violence in their workplace settings to join me in a research project. This thesis research study asks you to participate in: a pre-workshop interview; a *Focusing* workshop; and a follow-up workshop interview.

Focusing is a skill for gaining self-awareness and workshops are conducted world-wide. It involves a self exploration based on listening to the body's wisdom. Eugene Gendlin (the founder of *Focusing*) suggests that our bodies and brains know much more than we are aware of. *Focusing* helps gain this greater awareness. The experience of *Focusing* therefore, can assist in shifting from experiencing the problem towards moving forward in life. The key discovery in the evidence-based research on *Focusing* is that people's ability to affect personal change depends on how closely people attend to their body-mind experiencing.

Confidentiality and privacy will be emphasized in this thesis research project which has been approved by St. Stephen's College Research Ethics Committee.

I expect that the research will be conducted between July and November, 2010. Each interview will likely last about an hour. The *Focusing* workshop will be seven hours. If you are interested in joining me in this research project please reply in confidence before July 15th, 2010 for this important research. Anonymity is guaranteed. You can reach me by telephone at (306) xxx 5593.

Appendix B

A series of questions during the preliminary telephone interview:

1. Have you been yelled at more than once in your workplace by your colleagues (other nurses, physicians, continuing care aides, physical therapists, occupational therapists, social workers, etc.)?
2. Have you felt consistently excluded from everyday conversations in your workplace?
3. Have other co-workers been frequently talking about you in negative terms?
4. Have you felt constantly criticized by your co-workers?
5. Have you felt extremely unsupported by your co-workers?
6. Have you felt unaccepted as a person by your co-workers in your workplace?

Appendix C

Pre-workshop Interview Questions:

I am interested in hearing a metaphor, a story, or could you describe a visual picture of how your workplace violence experience made you feel and how the experiences of violence affected you. (main open question)

- What happened during these experiences? What did you do? (probing questions)
- How has these experiences affected your sense of yourself? (probing questions)
- Follow-up workshop Interview Questions:
- When we first spoke one month or so ago, I asked you about a metaphor, story or an explanation of a picture and you said, ".....". To what extent does that metaphor/story/picture reflect the way you feel now?
- What do you think were the reasons for the change or no change in perceptions regarding your workplace violence experiences?
- How has the workplace experiences in your workplace changed or not changed?
- Do you have anything else you would like to say?
- The following could be used as *Focusing* workshop follow-up probing questions:
- To what extent do you continue to experience workplace violence?

Appendix D

Letter of the Purpose of my Research Project

Dear Potential Co-Researcher

The purpose of my research project is to study the use of *Focusing* for nurses who have experienced intercollegial workplace violence. You will be asked to describe your experience of workplace violence during the pre and follow-up *Focusing* workshop interviews.

Intercollegial violence can be defined as "sustained exposure to violence in the workplace, including aggression, abuse and bullying" occurring from colleague to colleague. This horizontal/lateral/intercollegial violence is viewed as the following shaming behaviours: breaking confidences, infighting, scape-goating, lack of respect for privacy, non-verbal posturing, withholding information, verbal affronts, backstabbing, undermining activities, and sabotaging other colleagues. These shaming behaviours, whether intentional or unintentional, can cause serious physical, social, emotional, mental and spiritual harm to individuals and to the entire workplace environment.

Focusing is a skill for gaining self-awareness and workshops are conducted world-wide. It involves a self-exploration based on listening to the body's wisdom. Eugene Gendlin (the founder of *Focusing*) suggests that our bodies and brains know much more than we are aware of. *Focusing* helps gain this greater awareness. The experience of *Focusing* therefore, can assist in shifting from experiencing the problem towards moving forward in life. The key discovery in the evidence-based research on *Focusing* is that people's ability to affect personal change depends on how closely people attend to their body-mind experiencing.

I am very interested in exploring the use of *Focusing* with people who have suffered harm from workplace violence directed at them. It is my hope that you would be interested in this possibility as well.

Thank you for considering joining me in this interesting project, as we explore it in more depth. For further questions please contact me at (306) xxx 5593.

Warm regards

Sherry McDonald, RN, BScN, MAPPC Candidate

Appendix E

Instructions to Co-researcher

Date:

Dear Co-researcher

Thank you for your interest in my thesis research project on, Nurses' Experience of Workplace Violence before and after a *Focusing* Workshop.

Workplace violence within the context of this thesis project is described as a "misuse of power and control" and can be experience as shaming behaviours such as aggression, abuse, marginalizing, and bullying. These shaming behaviours, whether intentional or unintentional, can cause serious physical, social, emotional, mental and spiritual harm to individuals and to the entire workplace. I am interested in your experiences of intercollegial workplace violence and how *Focusing* may impact on your experience.

I value your unique contribution to my thesis project and am very pleased about the possibility of your participation in it. The purpose of this letter is to elaborate some of the things that have been presented in the letter of the purpose of my research project and to secure your signature on the Informed Consent form that is attached.

It is important to reinforce that your participation remains voluntary at all times. You can withdraw from the study or decide not to answer any question at any time by simply saying so. Your identity will be kept anonymous, meaning that any information you provide will not be associated with your name and that any identifying details will be disguised in the final thesis and related publications.

Through your participation as co-researcher, I hope to understand the essence of your lived experience of intercollegial workplace violence before and following a

Focusing workshop. This study does not involve deception of any kind and you are free to ask me anything regarding the methods or procedures of this research at any time.

The *Focusing* workshop will be experiential in nature and include an evidenced-based definition and description along with several exercises to assist you the co-researcher in learning how to access your body's inner wisdom. You will be encouraged to practice *Focusing* in a dyad or triad with my ongoing support. The *Focusing* workshop will be approximately seven hours with three nutritional breaks. Questions during this experiential workshop are encouraged.

Through a pre-workshop interview, you will be asked to describe your workplace violence using a metaphor of your experience. Following the *Focusing* workshop, you will be asked to return to your original metaphor and describe any possible changes to the initial metaphor. You will be invited to tell me in as much detail as you need to about these specific experiences and how this impacted your relationship with yourself, your environment and your spiritual life.

Following each interview that has been transcribed by a professional transcriptionist, I will return that transcript to you by Priority Post for any revisions or additions that you feel necessary to ensure completeness and accuracy. You will be invited to telephone me to revise, correct, add to, or change anything you need to so that whatever is articulated in the transcripts feels as accurate as possible regarding your experience.

Once I have completed all interviews and the data analysis phase is complete, I will also prepare a description of your experiences incorporating the themes present in

the research data. If you wish a copy of the final thesis, I will provide a copy to you upon completion of the thesis research project.

I thank you for your commitment of time, energy and participation in this project as I value your participation. If you have further questions or concerns before signing the Informed Consent Form, I can be reached at (306) xxx-5593.

Warm regards

Sherry McDonald, RN, BScN, MAPPC Candidate

Appendix F

Informed Consent

Nurses' Experience of Workplace Violence before and after a Focusing Workshop

The purpose of this study is to explore the experience (s) of a nurse experiencing intercollegial workplace violence and to study *Focusing* as a potential intervention.

Names and information that might identify you as a co-researcher will not be used. Only the researcher and a professional transcriptionist will have access to the audiotapes.

Co-researchers will be asked to take part in a pre-workshop interview and a follow-up workshop interview at a place of your choice that is conducive to safety, confidentiality and comfort for you. The purpose of these interviews is to explore your experience(s) of workplace violence. Following this pre- workshop interview you will be asked to participate in the *Focusing* workshop with five other nurses.

Three to four weeks following the *Focusing* workshop co-researchers will be asked to take part in a follow-up workshop interview. A second interviewer will be interviewing the co-researcher about their experience(s) of workplace violence. All interviews will be recorded on audiotape and transcribed.

A draft of each transcript will be returned to the co-researcher via Priority Post and the co-researcher will have the opportunity to telephone the researcher to revise, correct, add to, or change anything needed to ensure an accurate representation of their experience(s). The full transcripts will NOT be included in the thesis. However, excerpts or quotes may be included in the final text and/or future publications without any mention of your name.

A mental health professional will be available to support and debrief the interview experience should the need arise.

Please circle the desired yes or no statements:

- I understand that my participation is entirely voluntary; that I can refuse to answer any question at any time, and that I can withdraw from the study at any time without explanation and without risk of consequences to myself.
  Yes No
- I agree to participate in this inquiry knowing that, as research, it is an exploration and may or may not yield benefit to others or myself.
  Yes No
- I understand that I will not be paid for participating in this project.
  Yes No
- Information about this research has been discussed with me by the Researcher, Sherry McDonald. I have read and understood this information. Yes No

I have reviewed this consent form and grant permission for my information to be used in the research as described above in the process of completing a Master of Art in Pastoral Psychology and Counselling degree at St. Stephen's College, including a thesis and any other future publications.

_____	_____
Research Participant	Researcher
_____	_____
Date	Date

If you have any questions or concerns at any time, please contact the researcher at (306) xxx 5593. You may also contact her thesis supervisor, Dr. Leslie Gardner at xxx@xxx.ca or Dr. Julie Henkelman, MAPPC Program Coordinator at St. Stephen's College at (780) xxx-7311.

Appendix G

Confidentiality Form for the Transcriptionist

I have agreed to type all the transcriptions for Sherry McDonald's Thesis Project, *Nurses' Experience of Workplace Violence before and after a Focusing Workshop.*

I have also agreed to keep all information pertaining to the transcriptions confidential respecting the principles of respect for privacy, confidentiality and dignity of the participants involved in this thesis project.

_____	_____
Transcriptionist	Researcher
_____	_____
Date	Date

Appendix H

Confidentiality Form for the Second Interviewer

I have agreed to keeping confidentiality for interviews I facilitate within Sherry McDonald's Thesis Project, *Nurses' Experience of Workplace Violence before and after a Focusing Workshop.*

I have also agreed to keep all information pertaining to the transcriptions confidential respecting the principles of respect for privacy, confidentiality and dignity of the participants involved in this thesis project.

_____	_____
Second Interviewer	Researcher
_____	_____
Date	Date

Appendix I

Confidentiality Agreement

I, _____, have agreed to keep all content shared in this *Focusing* Workshop in confidence respecting the privacy of the co-participants. I will not share any names or any sharing of information during this workshop to anyone outside of the workshop.

Name

Date

Witness

Date

Appendix J

Ethics Form

COPY

ST. STEPHEN'S COLLEGE

25 June 2010

Sherry McDonald

Dear Sherry,

Re: Research Ethics Review Application

The Research Ethics Committee has had an opportunity to review your research ethics documents and have approved your proposed research.

I wish you well as your proceed into the research phase and look forward to receiving your thesis next spring.

Sincerely,

Dr. Julie Henkelman, R. Psych
MAPPC Coordinator

cc : Leslie Gardner

T. STEPHEN'S COLLEGE, UNIVERSITY OF ALBERTA CAMPUS, 8810-112 STREET, EDMONTON, AB CANADA T6G 2J6
PHONE: 780-439-7311, TOLL-FREE: 1-800-661-4956 FAX: 780-433-8875 WWW.UALBERTA.CA/ST.STEPHENS/

Ethics Form continued

COPY

ST. STEPHEN'S COLLEGE
RESEARCH ETHICS COMMITTEE
Ethics Review Consensus Form

Name: M. Sherry McDonald

Email:

Project Title: Nurses' Experience of Workplace Violence before and after a Focusing Workshop

---

Status: X MAPPC ☐ MTS ☐ D.Min. ☐Other:_____ (Specify)

Ethic Review Status:

☑ Review approved by Research Ethics Committee. Panel

☐ Review approved with revisions required.

☐ Application not approved by Research Ethics Committee Panel

Dean Clandinin
Signature of REC Panel Convener

B. Kiely
Name of Panel Member

June 22/2010
Date

T Davey
Name of Panel Member

Comments or Recommendations: