AN APPRECIATIVE INQUIRY OF PSYCHIATRIC NURSES' EXPERIENCE OF WORKPLACE SUPPORT IN A PRIVATE MENTAL HEALTH CARE SETTING

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DECLARATION

DECLARATION

This serves to confirm that I, Maria, Catharina, Isabelle, Swart (6809200033080), declare that the research, *An Appreciative Inquiry of Psychiatric Nurses' Experience of Workplace Support in a Private Mental Health Care Setting*, is my own work and has not been submitted for a degree or an examination at any other university. I further declare that all sources used and quoted in this research has been acknowledged and reflected in the reference list.

Signed at Pretoria on this 30 day of May 2011.

M.C.I. Swart

DEDICATION

To my Father

You have always given me everything in abundance.

Thank you

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SUMMARY

Workforce shortages are a major concern of health care and the creation of a positive workplace is central to the attraction and retaining of employees where employees are motivated to be loyal towards their employer by a positive work experience rather than by financial rewards (Manion, 2009:XIII). This positive work experience can include the providing of workplace support that is tailored to the specific experiences and wishes of psychiatric nurses working at a private mental health care setting. Work demands encountered by psychiatric nurses can vary from personal stresses related to the interpersonal nature of working with the challenging behaviour of mental health care users, to environmental stresses related to an environment reflecting inadequate workplace support.

Stuart and Laraia (2005:11) described the role of the psychiatric nurse in any mental health care setting as depending on certain factors in the organisation. This include the philosophy, goals, prevailing understanding of mental health, the needs of the mental health care users, number of available personnel, communication structure, understanding of their individual roles, available resources and the presence of effective nurse mentoring.

As a professional psychiatric nurse, I identified the need for effective workplace support to psychiatric nurses working in a private mental health care setting by observing signs of burnout in psychiatric nurses and by listening to employees verbalising their need for workplace support.

The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. The objectives of the research were to explore and describe the experiences of psychiatric nurses regarding workplace support, to explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting and to propose recommendations regarding workplace support. Proposed recommendations will have reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice, in order to facilitate more effective means to provide workplace support and to facilitate the promotion of the mental health of psychiatric nurses.

I decided to use an Appreciative Inquiry framework in order to explore the experiences and wishes of psychiatric nurses regarding workplace support. The importance of Appreciative Inquiry lies in the appreciation of the behaviour and the responses of individuals instead of focusing on their problems. Appreciative Inquiry identifies that which is positive in any system and connects to or builds on it in order to "heighten energy, vision and action for change" (Cooperrider, Whitney & Stavros, 2008:XV).

The meta-theoretical perspective that guided this researcher was the Theory for Health Promotion in Nursing. The essential purpose of this theory is health promotion for an individual, group, family or community (University of Johannesburg, 2009:4). The individual is in interaction with the environment, which consists of an internal and external environment. The internal environment comprises the body, mind and spirit dimensions of the individual. The external environment comprises the physical, social and spiritual dimensions of the individual. The interactions of these dimensions in the environment of the individual influence the health status of the individual on a continuum (University of Johannesburg, 2009:5). The experiences and wishes regarding the providing of workplace support pertaining to the internal and external environments of the psychiatric nurse were examined in order to facilitate the promotion of the mental health of the psychiatric nurse.

The theoretical and methodological perspective that guided this research was Appreciative Inquiry. Appreciative Inquiry uses a process known as the 4-D cycle, which is the process that is employed to facilitate change or to generate the power of Appreciative Inquiry (Whitney & Trosten-Bloom, 2003:6). For this research on workplace support, I employed the first two phases of Appreciative Inquiry, namely the discovery phase and the dream phase as part of the data collection. The discovery phase involves the appreciation or discovering of that which is positive, life giving or effective and the dream phase involves the imagining of new possibilities.

As a unique paradigm, Appreciative Inquiry questions traditional approaches to problem solving by accepting organisational challenges using an affirmative approach. An affirmative approach includes an appreciation of the positive by focussing on successes, strengths and potential (Cooperrider, Whitney & Stavros, 2008:433). Appreciative Inquiry views organisations as an individual centre of immense imagination and possibilities, intended to function as solutions (Cooperrider, Whitney & Stavros, 2008:16-17).

I used a qualitative design, which was exploratory, descriptive and contextual. I integrated an Appreciative Inquiry approach into this design.

I used purposeful sampling, which Polit and Beck (2007:763) define as a sampling method where participants are selected based on who will be the most informative regarding the topic of the research, namely workplace support in this research. The data collection methods used was naïve sketches, small core group inquiries and individual interviews with members of nursing management. The small core group inquiries included written answers on the interview schedule from the one-on-one interviews, transcribed feedback from the discussion phase, the positive core map, the nominal group technique, field notes and reflective interviews. The small core group inquiries were structured around one-on-one interviews that participants conducted with each other in groups of two, using an interview schedule. During the data analysis phase, I used two different techniques in order to analyse the available data, namely the nominal group technique and open coding.

I used a tree as symbol for workplace support at this mental health care setting. The roots of the tree symbolised the willingness of management to provide workplace support to their employees. The trunk of the tree symbolised the holistic approach to workplace support. The branches of the tree symbolised the identified themes. I represented the discovery phase categories as the green leaves of the tree. I represented the dream phase categories as pink buds.

I proposed recommendations relating to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice. The aim of these recommendations was to facilitate more effective means of providing workplace support, from a holistic perspective, in order to facilitate the promotion of mental health of psychiatric nurses working at this mental health care setting.

OPSOMMING

Tekorte in die arbeidsmag is 'n bron van groot besorgdheid vir gesondheidsorg, en die skep van 'n positiewe werkplek is sentraal tot die aantrekking en behoud van werknemers in gevalle waar werknemers deur middel van 'n positiewe werkservaring, eerder as 'n finansiële vergoeding, gemotiveer word om lojaal teenoor hul werkgewer te wees (Manion, 2009:XIII). Hierdie positiewe werkservaring kan die verskaffing van werkplekondersteuning, wat op die spesifieke ervarings en wense van psigiatriese verpleegspraktisyns wat in 'n privaat geestesgesondheidsomgewing werk, geskoei is, insluit. Werkseise wat psigiatriese verpleegspraktisyns teëkom kan wissel van persoonlike stres verwant aan die interpersoonlike aard van om met die uitdagende gedrag van geestesgesondheidsgebruikers te werk, tot omgewingstres verwant aan 'n omgewing wat ontoereikende werkplekondersteuning bied.

Stuart en Laraia (2005:11) beskryf die rol van 'n psigiatriese verpleegspraktisyn in enige geestesgesondheidsomgewing as afhanklik van sekere faktore in die organisasie. Dit sluit die filosofie, doelwitte, heersende begrip van geestesgesondheid, die behoeftes van die geestesgesondheidsgebruikers, die aantal beskikbare personeel, die kommunikasiestruktuur, begrip vir die individuele rolle, beskikbare hulpbronne en die teenwoordigheid van effektiewe verpleegsbegeleiding in.

As 'n professionele psigiatriese verpleegspraktisyn het ek die behoefte aan effektiewe werkplekondersteuning vir psigiatriese verpleegspraktisyns wat in 'n privaat geestesgesondheidsomgewing werk, waargeneem toe ek na tekens van uitbranding by die psigiatriese verpleegspraktisyns opgelet het, en na die werknemers geluister het wanneer hulle hul behoefte aan werkplekondersteuning verwoord het.

Die doel van hierdie studie was om 'n Waarderende Ondersoek te loods ten einde 'n indiepte begrip van die ondervindings en wense van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning in 'n privaat geestesgesondheidsomgewing te bewerkstellig. Die doelstellings van die studie was om die ondervindings van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning te beskryf ten einde die wense van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning in 'n privaat geestesgesondheidsomgewing te ondersoek en te beskryf en om aanbevelings te maak met betrekking tot werkplekondersteuning. Voorgestelde aanbevelings verwys na psigiatriese verpleegsnavorsing, psigiatriese verpleegsopleiding, psigiatriese

verpleegs-bestuur en psigiatriese verpleegspraktyk, om meer effektiewe metodes te fasiliteer ten einde werkplekondersteuning te voorsien en die geestesgesondheid van psigiatriese verpleegspraktisyns te bevorder.

Ek het besluit om 'n Waarderende Ondersoekraamwerk te gebruik te einde die ervarings en wense van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning te ondersoek. Die belangrikheid van 'n Waarderende Ondersoek lê in die waardering van die gedrag en terugvoer van individue, in plaas van om op hul probleme te fokus. Waarderende Ondersoek identifiseer dit wat positief is in enige stelsel en sluit daarby aan of bou daarop om energie, visie en aksie vir verandering te verhoog (Cooperrider, Whitney & Stavros, 2008:XV).

Die meta-teoretiese perspektief wat die navorser gelei het, was die Teorie vir Gesondheidsbevordering in Verpleging. Die hoofdoel van hierdie teorie is die gesondheidsbevordering van 'n individu, groep, gesin of gemeenskap (Universiteit van Johannesburg, 2009:4). Die individu is in interaksie met die omgewing, wat uit 'n interne en eksterne omgewing bestaan. Die interne omgewing sluit die liggaamlike, verstandelike en geestelike dimensies van die individu in. Die eksterne omgewing sluit die fisiese, sosiale en geestelike dimensies van die individu in. Die interaksies van hierdie dimensies in 'n individu se omgewing beïnvloed die gesondheidstoestand van die individu op 'n kontinuum (Universiteit van Johannesburg, 2009:5). Die ervarings en wense met betrekking tot die voorsiening van werkplekondersteuning wat met die interne en eksterne omgewings van die psigiatriese verpleegpraktisyn verband hou, is ondersoek ten einde die bevordering van die geestesgesondheid van die psigiatriese verpleegpraktisyn te fasiliteer.

Die teoretiese en metodologiese perspektief wat hierdie studie gelei het, was Waarderende Ondersoek. Waarderende Ondersoek gebruik 'n proses wat as die 4-D siklus bekend staan. Hierdie proses word gebruik om verandering te fasiliteer of om die krag van Waarderende Ondersoek te verseker (Whitney & Trosten-Bloom, 2003:6). Vir hierdie navorsing oor werkplekondersteuning het ek die eerste twee fases van Waarderende Ondersoek, naamlik die ontdekkingsfase en die droomfase, as deel van dataversameling gebruik. Die ontdekkingsfase sluit die waardering of ontdekking van wat positief, lewegewend of effektief is, in, en die droomfase sluit die verbeelding van nuwe moontlikhede in.

As 'n unieke paradigma, bevraagteken Waarderende Ondersoek tradisionele benaderings tot probleemoplossing deur organisatoriese uitdagings met 'n regstellende ingesteldheid te

benader. 'n Regstellende benadering sluit die waardering van die positiewe in, deur op suksesse, sterkpunte en potensiaal te fokus (Cooperrider, Whitney & Stavros, 2008:433). Waarderende Ondersoek sien organisasies as 'n individuele sentrum met onmeetlike verbeelding en moontlikhede, met die voorneme om met oplossings vorendag te kom (Cooperrider, Whitney & Stavros, 2008:16-17).

Ek het 'n kwalitatiewe ontwerp, wat verduidelikend, beskrywend en kontekstueel van aard was, gebruik. Ek het 'n Waarderende Ondersoekbenadering met hierdie ontwerp geïntegreer.

Ek het doelbewuste steekproefneming, wat Polit en Beck (2007:763) definieer as 'n steekproefnemingsmetode waar deelnemers gekies word op grond van wie die meeste inligting oor die tema van die navorsing sal verskaf, wat in hierdie navorsing werkplekondersteuning is. Die dataversamelingsmetodes wat ek gebruik het, was naïewe sketse, klein kerngroep-ondersoeke en individuele onderhoude met lede van die verpleegsbestuur. Die klein kerngroep-ondersoeke het geskrewe antwoorde op die onderhoudskedule van die een-tot-een onderhoude, getranskribeerde terugvoer van die besprekingsfase, die positiewe kernkaart, die nominale groeptegniek, veldnotas en reflektiewe onderhoude ingesluit. Die klein kerngroep-ondersoeke was gegrond op een-tot-een onderhoude wat die deelnemers met mekaar, in groepe van twee, gevoer het, deur van 'n onderhoudskedule gebruik te maak. Tydens die dataontledingsfase het ek twee verskillende tegnieke gebruik om die beskikbare data te ontleed, naamlik die nominale groeptegniek en oopkodering.

Ek het 'n boom as simbool vir werkplekondersteuning in hierdie geestesgesondheidsomgewing gebruik. Die wortels van die boom het die bestuur se vrywilligheid om werkplekondersteuning aan hul werknemers te bied, gesimboliseer. Die stam van die boom het die holistiese benadering tot werkplekondersteuning gesimboliseer. Die takke van die boom het die geïdentifiseerde temas gesimboliseer. Die kategorieë van die ontdekkingsfase is deur die groen blare voorgestel, en die kategorieë van die droomfase deur pienk botsels.

Ek het aanbevelings gemaak met betrekking tot die psigiatriese verpleegsnavorsing, psigiatriese verpleegsopleiding, psigiatriese verpleegsbestuur en psigiatriese verpleegspraktyk. Die doel van hierdie aanbevelings is om meer effektiewe metodes vir

die verskaffing van werkplekondersteuning, uit 'n holistiese perspektief, te fasiliteer, ten einde die geestesgesondheidsbevordering van psigiatriese verpleegpraktisyns wat in hierdie geestesgesondheidsomgewing werk, te fasiliteer.

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CHAPTER 1

OVERVIEW OF THE RESEARCH

"Let the oil of knowledge and of love always ensure that your lamp burns brightly" - Charlotte Searle 1945 (Searle, 2007:VII).

1.1 INTRODUCTION

In order to assure brightly burning lamps for the psychiatric nurses working at the private mental health care setting where I was employed, management included various employee support themes in their in-service training programme for the year 2010. This included lectures from a physiotherapist on posture, a dietician on lifestyle choices and a psychologist on stress management.

It was further clear from a discussion I had with a member of the nursing management that the management of this mental health care setting was committed to the provision of workplace support to their employees. The reasons for being committed to providing workplace support to psychiatric nurses included the promotion of their mental health. Hunnicutt (cited in Dickens, Sugarman & Rogers, 2005:297) showed that nurses experienced less emotional fatigue when they experienced their workplace environment as being supportive. Emotional fatigue or burnout can also lead to psychological resignation which Manion (2009:14) describes as "a state of being". The resignation of psychiatric nurses does not have to be a behavioural action, but can include a psychological absence from their work leading to a decrease in productivity (Manion, 2009:14).

Having witnessed this emotional fatigue or psychological resignation of psychiatric nurses at a specific mental health care setting, I was curious about the particular experience of psychiatric nurses and their wishes regarding workplace support in this private mental health care setting. An additional, but equally important, motivation for me to do the research was the promotion of the mental health of psychiatric nurses working at this specific mental health care setting. I intended to facilitate the promotion of the mental health of these psychiatric nurses by providing them with the opportunity to share their stories regarding workplace support as participants and by proposing recommendations in order to facilitate more effective means to provide workplace support. "Mental health status means the level

of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis" (Government Gazette, 2002).

Richer, Ritchie and Marchionni (2009) suggest the use of an Appreciative Inquiry approach in research in order to promote original ideas and to provide health care workers with an opportunity to "explore the possibilities for change". The purpose of this research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. Psychiatric nurses refer to "mental health care providers meaning a person providing mental health care services to mental health care users and includes mental health care practitioners" (Government Gazette, 2002).

Based on the findings I proposed recommendations to facilitate more effective means to provide workplace support in the identified context with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice.

In chapter one, I will present the background and rationale for my research. I will provide the problem statement, the research questions and the research objectives. I will also discuss the paradigmatic perspectives of the research, the research design and the research methodology. I will include a section defining all the main concepts in the research. Finally, I will discuss the significance of this research.

1.2 BACKGROUND AND RATIONALE

Worldwide there are psychiatric nurses who are passionate to influence the lives of mental health care users in their care, yet they struggle with related pressures of inadequate means, challenging behaviours of mental health care users and environments that are stigmatised, lack of availability of suitable services, governmental and guideline concerns, as well as administrative needs (McCabe, 2005:35). Work demands encountered by psychiatric nurses can thus vary from personal stresses related to the interpersonal nature of working with the challenging behaviour of mental health care users to environmental stresses related to an environment reflecting inadequate workplace support. Fink-Samnick (2008:338) explains how the shift from patient care to "the care of the business of health care" guided the increase in the attention to better quality of service resulting in an increase in work demands.

Extensive studies have been conducted worldwide relating to the need for and the occurrence of workplace support for nurses. Bégat, Ellefsen and Severinsson (2005:222) show that occupational stress is increasing among nurses from Britain, Scotland and Norway. Chen, Hwu and Williams (2005:141) indicate that psychiatric nurses from Taiwan are at risk of assault from mental health care users. Tourangeau, McGillis Hall, Doran and Petch (2006:128-9) discuss the satisfaction of Canadian nurses in regards to safety, social and psychological aspects, where aspects relating to the safety of the nurses showed the highest correlation with work satisfaction, followed by the psychological aspects and the social aspects showed a medium correlation with work satisfaction.

The emphasis on the need for workplace support is further highlighted by the shifting focus in health care from illness to health and well-being as a way of preventing the onset of a disease. A supportive workplace milieu is thus one in which there is approachable communication between personnel at all levels, acknowledgment of the efforts of nurses, interdisciplinary consideration, the involvement of nurses in choices concerning care and the environment of the mental health care users, delegation of tasks, personal and professional growth opportunities and encouragement (Stuart & Laraia, 2005:11).

Fagerström (2006:626) writes that the work environment of nurses can be characterised by feelings of chaos; nurses sometimes feel out of control and that their capacity is insufficient. This can be especially relevant to the work environment of psychiatric nurses due to the behavioural challenges that mental health care users pose. According to research performed by Pompili, Rinaldi, Lester, Girardi, Ruberto and Tatarelli, (2006:142) psychiatric nurses are more prone to burnout due to the fact that they require knowledge and skills owing to the unique features of psychiatric nursing.

Knowledge and skills that are required by psychiatric nurses include having to deal with the interpersonal and intrapersonal dynamics of the mental health care users (Uys, 2004:15), in other words “nursing care can be understood as consisting of complex and meaningful caring situations” (Fagerström, 2006:622). This is only possible if the care giver, or the psychiatric nurse in this research, is both physically and mentally healthy, which Fagerström (2006:622) explains as referring to a state of optimal functioning and not just the absence of illness.

The World Health Organisation (cited in Sadock & Sadock, 2007:12) acknowledges that health is “complete physical, mental and social well-being”, where mental health presumes

"the absence of mental disorder". Sadock and Sadock (2007:12) continue to describe mental health as the effective performance of mental activities, relating to thought, behaviour and mood, resulting in the ability to transform, to manage complexity, to function productively and to sustain satisfying relationships.

Stress, on the other hand, which can lead to burnout, can be described as situations that disrupt, or are likely to disrupt, the normal psychological or physiological performance of someone (Sadock & Sadock, 2007:813). Bégat et al. (2005:221) identified various factors that can contribute to experiencing stress in the work environment. These factors include relationships with colleagues, lack of communication, work-related demands and anxiety, lack of motivation, insufficient professional development, feelings of being out of control, ethical conflict, lack of independence in decision-making and conflicting values. These stresses necessitate the implementation of workplace support for psychiatric nurses in order to promote their mental health.

Stuart and Laraia (2005:11) describe the use of oneself as the key therapeutic tool of the psychiatric nurse. Psychiatric nurses work in environments that are varied in location, function, nature and structure, and the overall policy of these organisations regarding workplace support can promote or limit the mental health and potential of psychiatric nurses (Stuart & Laraia, 2005:11). Part of the objective of this research was thus to propose recommendations regarding workplace support in order to promote the mental health of psychiatric nurses working at this mental health care setting.

Stuart and Laraia (2005:11) continue to describe the role of the psychiatric nurse in any mental health care setting as depending on certain factors in the organisation. These factors include the philosophy, goals, prevailing understanding of mental health, needs of the mental health care users, number of available personnel, communication structure, understanding of their individual roles, available resources and presence of effective nurse mentoring.

The role of psychiatric nurses in the context in which the research was conducted included the admission of mental health care users, including the conducting of an assessment interview and the crafting of a nursing care plan, continuous observation and daily interviews with the mental health care users, as well as the writing of reports and the adjusting of the nursing care plans accordingly. Additional tasks of psychiatric nurses include the administering of medication, the coordination of the daily programme of each mental health

care user and the performance of crisis intervention where necessary. Psychiatric nurses in this specific context, namely a private, short-term, in-patient mental health care setting in Gauteng, shared their experiences and wishes regarding workplace support, including the facilitating and restraining factors, with me during the data collection phase of this research.

As a professional psychiatric nurse, I identified the need for effective workplace support for psychiatric nurses working in a private mental health care setting by observing signs of burnout in psychiatric nurses and by listening to employees verbalising their need for workplace support. Observed signs of burnout included emotional exhaustion, feelings of detachment, cynicism and feelings of being ineffective at work.

Spence Laschinger and Leiter (2006:260) attributed signs of burnout in psychiatric nurses to the possible high-client turnover rate, a demanding work environment, lack of sufficient personnel and the resulting working of overtime by the existing personnel, factors that are all present at the mental health care setting where this research had been performed.

As discussed earlier in the introduction section, I identified willingness from management at the mental health care setting where the research was done to explore more effective means of providing workplace support to psychiatric nurses employed by them. The theme of workplace support also correlated with the in-service training theme at the time of the data collection for this research, namely employee support, at the mental health care setting where the research was conducted.

After being introduced to Appreciative Inquiry by one of my supervisors, I decided to use an Appreciative Inquiry framework to explore the experiences and wishes of psychiatric nurses regarding workplace support. The importance of Appreciative Inquiry lies in the appreciation of the behaviour and the responses of individuals instead of focusing on their problems. Appreciative Inquiry is fundamentally about changing our concepts of how changes occur, how people behave and how research can be a factor in this process (Reed, 2007:2).

Appreciative Inquiry was first used by David Cooperrider in 1980 when he used an analysis method of “deliberately appreciating everything of value”, and using this “positive analysis to speculate on the potentials and possibilities for the future”, relating to organisations (Cooperrider, Whitney & Stavros, 2008:XXVII). In other words, Appreciative Inquiry identifies that which is positive in any system and connects or builds on it in order to “heighten energy, vision and action for change” (Cooperrider, et al. 2008:XV).

In order to identify the positive at this mental health care setting regarding workplace support, I wanted to explore the peak experiences of psychiatric nurses regarding workplace support, in other words, I wanted to explore which methods of the existing workplace support psychiatric nurses experienced as being effective. Appreciative Inquiry is used worldwide in initiatives and can be used in combination with other organisational change processes like coaching, leadership development, cultural transformation, strategic planning, team building or the redesign of systems (Cooperrider, et al. 2008:XV).

"Appreciative Inquiry is a philosophy that incorporates an approach … for engaging people at any or all levels to produce effective, positive change" (Cooperrider, et al. 2008:XV). I envisioned this change in workplace support by the implementation of the proposed recommendations discussed in chapter 4.

The 4-D cycle is the process that is employed to facilitate change or to generate the power of Appreciative Inquiry (Whitney & Trosten-Bloom, 2003:6). The 4-D cycle of Appreciative Inquiry consists of four phases, namely the Discovery phase, the Dream phase, the Design phase and the Delivery phase. The Discovery phase involves the appreciation or discovery of that which is positive, life giving or effective; the Dream phase involves the imagining of new possibilities; the Design phase involves the construction of the future; the Delivery phase involves taking action in order to create a better existence (Cooperrider, et al. 2008:6-7).

For this research on workplace support I employed the first two phases of Appreciative Inquiry, namely the Discovery phase and the Dream phase, as part of the data collection, which included the formulation of a positive core map. A positive core map is a visual illustration or summary of the resources, strengths and possibilities of the organisation (Cooperrider, et al. 2008:57). I will discuss the 4-D cycle and the positive core map in detail in chapter 2.

The Appreciative Inquiry approach to organisational development is relatively new, but as Bushe and Kassam (2005:162) proclaim, "Appreciative Inquiry is in a time of exponential growth". Havens, Wood and Leeman (2006) listed various examples of Appreciative Inquiry used in health care organisations, for example at the Lovelace Health System in Albuquerque, to improve vacancy rates, contentment, communication and productive interaction between health professionals.

Jackson, Firtko and Edenborough (2007:7) appeal, "It is timely to explore innovative ways of nurturing and supporting nurses so that they are better able to thrive and sustain satisfying careers even in contexts of organisational difficulty and workplace adversity". This context of organisational difficulty and the need for ways to support psychiatric nurses in the workplace at this mental health care setting led to the formulation of the problem statement below.

1.3 PROBLEM STATEMENT

It is generally agreed (Craft Morgan & Lynn, 2009:402; Lautizi, Laschinger & Ravazzolo, 2009:446; Leiter & Maslach, 2009:331; Seed, Torkelson & Alnatour, 2010:160) that workforce shortages worldwide among nurses are a major concern to health care. The creation of a positive workplace is central to the attraction and retaining of employees where employees are motivated to be loyal towards their employer by a positive work experience rather than by financial rewards (Manion, 2009:XIII). Newton, Kelly, Kremser, Jolly and Billett (2009:392) appeal to researchers that innovative methods are needed to encourage nurses to remain in the profession. In order to identify ways of providing a positive work experience, research on the work environments of nurses increased, however research regarding the correlation between stress and the work environment of psychiatric nurses is limited (Hanrahan, Aiken, McClaine & Hanlon, 2010:198).

A positive work experience can include the provision of workplace support that is tailored to the specific wishes of psychiatric nurses working in a mental health care setting. Mann and Cowburn (2005:156) describe how many of the pressures experienced by psychiatric nurses are from an organisational origin rather than from the involved nature of client care. They continue to describe factors such as lack of training, uncertainty, organisational change and administrative factors, and how ineffective workplace support can be detrimental to the mental health of the psychiatric nurse, ultimately leading to burnout.

A context experienced as providing insufficient workplace support can have a negative impact on the mental health of the psychiatric nurse and can consequently influence the quality of client care in the mental health care setting. McGee (cited in Jackson, et al. 2007:5) suggests that the promotion of personal growth in nurses is essential because "it is not possible for them (psychiatric nurses) to give patients what they do not themselves possess". I would like to extend this to workplace support by proposing that nurses who do not experience support at work would find it challenging to be supportive towards the mental health care users in their care.

If psychiatric nurses experience workplace support to be ineffective, it might even cause them to leave the profession altogether, especially when they are young or inexperienced in psychiatric nursing, as Manion (2009:10) illustrated. It is important for the mental health care setting to minimise the turnover of psychiatric nurses, since Ward and Cowman (2007:454) alert us that there are severe shortages of psychiatric nurses worldwide. There are also economical reasons to ensure the availability of psychiatric nurses. Lacey and Cox (2007) declare that "Adequate and appropriate staffing levels make good business sense and should be vigorously attended to". This is important due to the private nature of this context, as mental health care users in a private context might expect more in terms of the availability of psychiatric nurses.

I could not find relevant information pertaining to workplace support for psychiatric nurses working in mental health care settings in South Africa, by making use of the CINAHL and OVID databases.

The ultimate purpose of this research was to promote the mental health, and in so doing also the overall health, of psychiatric nurses by exploring their experiences and wishes regarding workplace support and by proposing recommendations to facilitate the implementation of more effective ways of providing workplace support.

There are currently 40 registered psychiatric nurses employed by the mental health care setting where I did the research. I will discuss the sample population in detail in chapter 2, paragraph 2.4.2.2, selection of participants. Members from the nursing management at the mental health care setting where the research was conducted were unable to provide me with statistics regarding the turnover rate and vacant posts.

I observed various actions of psychiatric nurses who acted in middle or senior nursing management positions like being physically available in the wards or demonstrating an open door policy, demonstrating a supportive attitude, integrating supportive themes into the in-service training programme and employing more efficient systems, like enhancing the medication administering procedures. These actions were all aimed at providing workplace support to psychiatric nurses working at this demanding private mental health care setting where I did my research. The workload at this setting is demanding due, in part, to the high turnover of mental health care users, with daily admissions and discharges throughout the year.

Despite all the efforts made by management to employ effective actions in order to provide workplace support to psychiatric nurses, I observed signs of burnout among psychiatric nurses. I observed an absence of interest in work, conflict among nursing colleagues, irritability and verbalisations of feeling tired and not receiving support. Okun and Kantrowitz (2008:302) describe burnout as feeling exhausted, being unable to concentrate, being irritable, experiencing altered sleep and eating habits and the absence of motivation and interest in work.

The problem that I identified was this apparent contradiction or disparity between the attempt of management to provide workplace support and the experiences of psychiatric nurses with regard to the available workplace support. This made me curious about the implication and effect of the current workplace support systems and more specific the experiences of psychiatric nurses with regards to current workplace support and the effectiveness thereof according to psychiatric nurses.

I was also conscious of the fact that those experiences may vary from examples given in literature. As Dickens et al. (2005:302) contended, I also suspected that nurses in one context might experience their working environment differently than reported in comparable research findings. I was also curious to explore the wishes of psychiatric nurses with regard to workplace support at this specific mental health care setting in order to propose specific recommendations based on their contextual experience.

My purpose was to conduct an Appreciative Inquiry to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in order to propose recommendations that may contribute to the promotion of the mental health of psychiatric nurses in a private mental health care setting.

1.4 RESEARCH QUESTIONS

Considering the discussed problem statement, I asked the following research questions based on the Appreciative Inquiry approach:

- what are psychiatric nurses' experiences of workplace support in a private mental health care setting, and

- what wishes could psychiatric nurses have regarding workplace support in a private mental health care setting?

1.5 PURPOSE AND OBJECTIVES OF THE RESEARCH

The purpose of the research was to conduct an Appreciative Inquiry to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

The objectives of the research were to:

- explore and describe the experiences of psychiatric nurses of workplace support in a private mental health care setting,

- explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting, and

- propose recommendations regarding workplace support with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice, in order to facilitate more effective means to provide workplace support and to facilitate the promotion of the mental health of psychiatric nurses.

1.6 PARADIGMATIC PERSPECTIVES

Polit and Beck (2008:761) define a paradigm as a philosophical statement that directs the style of inquiry of the researcher into phenomena. The paradigmatic perspectives consist of the meta-theoretical perspective, the theoretical perspective and the methodological perspective.

I will discuss the Theory for Health Promotion in Nursing as the meta-theoretical perspective and Appreciative Inquiry as the theoretical perspective, along with the assumptions for each perspective individually. Finally I will discuss the methodological perspective of this research.

1.6.1 Meta-theoretical perspective

Meta-theoretical refers to the theoretical foundation of the research (Polit & Beck, 2008:683). The meta-theoretical perspective that guided this researcher was the Theory for Health Promotion in Nursing.

1.6.1.1 Theory for health promotion in nursing

The essential purpose of this theory is health promotion for an individual, group, family or community (University of Johannesburg, 2009:4). Health promotion for an individual, group, family or community transpires through the mobilisation of resources, including the promotion, maintenance and restoration of health (University of Johannesburg, 2009:5). The nursing process is used to provide care for an individual, group, family or community and includes activities of "assessment, planning, implementation and evaluation" as integrated and continuous activities (University of Johannesburg, 2009:5).

The individual is in interaction with the environment which consists of an internal and external environment. The internal environment comprises the dimensions of body, mind and spirit of the individual. The external environment comprises the physical, social and spiritual dimensions of the individual. The interactions between these dimensions in the environment of the individual influence the health status of the individual on a continuum (University of Johannesburg, 2009:5).

The experiences and wishes regarding the providing of workplace support pertaining to the internal and external environments of the psychiatric nurse will be examined in order to promote the mental health of the psychiatric nurse. Resources can be mobilised in the external environment in terms of workplace support that might facilitate mental health by strengthening resources in the internal environment of the psychiatric nurse.

1.6.1.2 Assumptions of the theory for health promotion in nursing

The following assumptions relating to the person, health, the environment, nurse and nursing, adapted in a context of psychiatric nursing, underlie the Theory for Health Promotion in Nursing (University of Johannesburg, 2009:4) and will provide the overarching meta-theoretical perspective in this research.

The psychiatric nurse as a person is holistically in interaction with the environment. The environment consists of an internal and external environment. According to the Theory for Health Promotion in Nursing, "the internal environment consists of dimensions of body, mind and spirit" and "the external environment consists of the physical, social and spiritual dimensions" (University of Johannesburg, 2009:5). "Body" includes all the physiological processes and anatomical structures, "mind" includes emotional, intellectual and volitional processes and "spirit" includes the relationships and conscience of the individual (University of Johannesburg, 2009:6). "Physical" includes chemical and physical structures, "social" includes all the human resources and "spiritual" includes the religious aspects and values of the individual (University of Johannesburg, 2009:6-7).

In this research I took care to explore the holistic experience of each participant, in accordance with the Theory for Health Promotion in Nursing, in order to obtain a holistic picture of experiences relating to workplace support. The holistic experience of psychiatric nurses is important, since they work from a holistic viewpoint in the providing of care to the mental health care users at this mental health care setting. See chapter 3, paragraph 3.3.3, holistic approach to workplace support, for a discussion of holistic support relating to the internal and external environments of the psychiatric nurse.

I did not formally define workplace support in terms of an internal or external environment during the core group inquiries, in order to obtain the personal description and explanation of workplace support of each participant relating to her personal experiences of workplace support in the internal and external environments. A core group inquiry, which is one of the ways of engagement in Appreciative Inquiry, is one of the data collection methods that I used in this research which involve participants who conducted one-on-one interviews with each other in pairs (Whitney & Trosten-Bloom, 2003:32) using an interview schedule (addendum E).

The health of the individual, or the mental health of the psychiatric nurse in this research, is an interactive process in these environments. The promotion of mental health is integrally linked to the dynamic interaction between the psychiatric nurse and the environment. Recommendations on how to facilitate more effective means of providing workplace support, with reference to psychiatric nursing management, research, education and practice, can aid in the mobilisation of resources in the internal and external environments of psychiatric nurses.

The aim of nursing is to facilitate health promotion as an interactive process between the nurse, as a therapeutic and sensitive professional, and the client (University of Johannesburg, 2009:4-5). In the context of this research health will refer to mental health. Health promotion will refer to the promotion of the mental health of the psychiatric nurse by the implementation of workplace support by members of senior and middle nursing management of this mental health care setting. This facilitation includes the "creation of a positive environment and mobilisation of resources, as well as the identification and bridging of obstacles" by demonstrating "knowledge, skills, attitudes and values" (University of Johannesburg, 2009:7).

According to the Theory for Health Promotion in Nursing the nurse is seen as a therapeutic and sensitive professional who demonstrates skills, knowledge and values in order to facilitate health promotion (University of Johannesburg, 2009:4). In this research, members of management, including senior and middle management, of this private mental health care setting can mobilise the resources with regard to workplace support, create a positive environment relating to workplace support and identify and overcome obstacles, thus implementing aspects of the nursing process to promote the mental health of psychiatric nurses employed by them.

The Theory for Health Promotion in Nursing describes the use of the nursing process as a methodology in providing nursing care and includes phases of assessment, planning, implementation and evaluation as integrated and continuous activities (University of Johannesburg, 2009:5). I linked the discovery and dream phases of Appreciative Inquiry to the assessment phase of the nursing process, since the collection of data relating to the identification of facilitating factors is central, both in the assessment phase of nursing and in the discovery and dream phases of Appreciative Inquiry. The discovery and dream phases are two phases of the four phases of the 4-D Cycle of Appreciative Inquiry which are "the process used to generate the power of Appreciative Inquiry" (Whitney & Trosten-Bloom, 2003:6).

1.6.2 Theoretical perspective

According to Polit and Beck (2008:142) the theoretical perspective is the all-embracing conceptual foundation of research. Appreciative Inquiry was the theoretical and methodological perspective that guided this research.

1.6.2.1 Appreciative inquiry

Appreciative Inquiry developed from the Social Constructionist paradigm which is based on the belief that social experiences are socially constructed and do not result from any objective principles (Terre Blanche, Durrheim & Painter, 2006:558). Experiences can thus only be understood by deconstructing their essential meanings. Cooperrider et al. (2008:14) continue to comment that Appreciative Inquiry uses the concept that a social system constructs or shapes its own reality by using a positive perspective.

As a unique paradigm, Appreciative Inquiry questions traditional approaches to problem solving by accepting organisational challenges using an affirmative approach. An affirmative approach includes an appreciation of the positive by focussing on successes, strengths and potential (Cooperrider, et al. 2008:433). Appreciative Inquiry views organisations as individual centres of immense imagination and possibilities, intended to function as solutions (Cooperrider, et al. 2008:16-17).

Traditionally research and intervention were seen as different and disconnected processes. By using the Appreciative Inquiry approach, research in itself can facilitate social transformation. Researchers acquire knowledge by the kind of questions they ask and the way in which they ask these questions. Appreciative Inquiry suggests that problems can be created simply by asking questions regarding problems. If the researcher, however, asks questions concerning the positive aspects of experiences, possibilities can be created (Reed, 2007:VIII).

Appreciative Inquiry uses a process known as the 4-D cycle to generate change, based on the idea that individuals and organisations evolve according to what is being studied. The 4-D cycle consists of the discovery phase, the dream phase, the design phase and the destiny phase. Whitney and Trosten-Bloom (2003:6) explained that Appreciative Inquiry focuses attention on the positive potential, or positive core, through the discovery phase, the dream phase, the design phase and finally the destiny phase. The positive core of an organisation includes hopes, dreams, strengths and possibilities (Whitney & Trosten-Bloom 2003:15).

Reed (2007:32-33) describes the discovery phase as a quest to find out more about the organisation, the dream phase is where participants develop ideas about the future, the design phase is where participants construct future plans and the delivery phase involves the planning of specific activities and making of commitments. Cooperrider et al. (2008:101)

illuminate the four phases by formulating a question for each phase. The discovery phase question is: “what gives life?”; the dream phase question is: “what might be?”; the design phase question is: “how can it be?”; and the destiny phase question is: “what will be?”. I will discuss these phases in more detail in chapter 2.

I compared the first two phases of Appreciative Inquiry, namely the discovery phase and the dream phase, with the first phase of the nursing process according to the Theory for Health Promotion in Nursing, namely the assessment phase. The reason for this comparison stemmed from one of the objectives of this research, namely to facilitate more effective means to provide workplace support and to promote the mental health of the psychiatric nurse, which resonates with an assumption of the Theory for Health Promotion in Nursing which states that the aim of nursing is to facilitate health promotion. Assessment involves the examination of the facilitating and interfering aspects in the internal and external environments of the individual (University of Johannesburg, 2009:8). The discovery and dream phases of the 4-D cycle of Appreciative Inquiry equally involve the examination of positive aspects in both the internal and external environments.

Based on the scope of the mini-dissertation and due to time constraints I decided to use only the first two stages of Appreciative Inquiry, namely the discovery and dream phases. The implementation and evaluation of the findings through the final two phases of design and destiny fell outside the research design as being exploratory and descriptive. The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experience and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

Attentive listening, which does not exclude negative information from the participants, is part of this process, subsequently moving the participant towards an appreciation of potential (Reed, 2007:IX). The process of giving the participating psychiatric nurses an opportunity to verbalise their experiences and wishes regarding workplace support produced a space that was conductive for the promotion of their mental health, as evidenced by the positive feedback on the opportunity to voice their experiences, as given by the participants after the small core group inquiries. This was evident when participants in this research verbalised an appreciation of the existing workplace support and demonstrated a positive attitude when verbalising their wishes for additional workplace support.

1.6.2.2 Assumptions of appreciative inquiry

Whitney and Trosten-Bloom (2003:54-55) discuss eight principles that guide the assumptions underlying Appreciative Inquiry. These principles are the constructionist principle, the simultaneity principle, the poetic principle, the anticipatory principle, the positive principle, the wholeness principle, the enactment principle and the free-choice principle.

According to Whitney and Trosten-Bloom (2003:54), the constructionist principle affirms that reality is subjective and individually constructed through narratives. The simultaneity principle indicates that inquiry is intervention and change can be facilitated by asking questions. The poetic principle shows how organisations are continuous sources of knowledge, and how the subject of research can be transformational in itself.

According to the anticipatory principle, individual systems will move in the direction that is envisioned and positive images can create positive actions. The positive principle shows how positive questions can strengthen the positive foundation including capabilities, strengths, skills, resources and assets. According to the wholeness principle, the whole organisation must be involved and wholeness facilitates the best in individuals and organisations. The enactment principle encourages individuals to be the change they aspire to and states that transformation takes place when there is a representation of the ideal future. The free-choice principle acknowledges the benefit of giving people autonomy (Whitney & Trosten-Bloom, 2003:55).

Reed (2007:27-28) discusses eight assumptions of Appreciative Inquiry that developed from these principles. I will discuss these assumptions by referring to the principles of Appreciative Inquiry, since the principles and assumptions of Appreciative Inquiry can be viewed as integrated. The assumptions are: in every organisation something works; what we focus on becomes our reality; there are multiple realities; the act of asking questions can influence the organisation; parts of the past must be carried with in order for organisations to journey to the future; we must carry the best of the past with us; it is important to value differences; our language creates our reality.

The first assumption is that there is something effective in every group, organisation or society, in other words something is working (Reed, 2007:27). This can be correlated to the positive principle of Appreciative Inquiry, which suggests that a positive focus will deeply

engage individuals. I aimed to support the positive principle by using positive questions. I also supported the principle during the feedback stage by encouraging positive ideas using communication techniques. The positive principle was also evident in the acknowledgement that methods were already employed to facilitate workplace support to psychiatric nurses. I will discuss this in more detail under the research methods section in chapter 2.

The second assumption describes how our reality develops from our focus (Reed, 2007:27-28), meaning that focus on the positive will direct a constructive realm. This can be compared to the anticipatory principle, which explains how systems move in the direction of the image they have of the future and the more positive the future image is, the more positive current actions will be. I aimed to incorporate this assumption by means of the positive focus of the research and the subject, namely workplace support. The reality of the participants regarding workplace support might have adjusted by focussing on actions that the participants experienced as being effective and supportive, thus positively influencing their attitudes and promoting their mental health.

The third assumption of numerous realities shows how there are different realities and that reality is shaped in the present (Reed, 2007:28). This assumption correlates with the constructionist principle that describes how different individuals can have diverse interpretations of their world, which I applied by exploring the distinctive experiences and wishes of each psychiatric nurse regarding workplace support individually. I also gave participants the opportunity to share their individual narratives during the discussion phase of the small core group inquiries.

I acknowledged that the need for workplace support and participant's individual experiences thereof and their individual wishes regarding workplace support in this specific mental health care setting might be different from each other and distinct from another mental health care setting concerning some aspects.

The nominal group technique, as part of the data analysis, which was used during the small core group inquiries, was an indication of how different participants preferred different themes regarding workplace support. Strydom (2005:419) suggest the use of the nominal group technique in order to prioritise the opinions of people regarding a challenge. The nominal group technique will be discussed in detail in chapter 2.

The fourth assumption is that individuals, groups or communities can be influenced just by

being questioned (Reed, 2007:28). This assumption can be linked to the simultaneity principle of Appreciative Inquiry, which suggests that questioning facilitates thinking and that thinking can facilitate a change in behaviour. I aimed at stimulating this thinking regarding workplace support by using carefully designed questions during the data collection in order to obtain an in-depth description of the experiences and wishes of participants regarding workplace support. These questions will be discussed in more detail in chapter 2, under data collection methods. I facilitated appreciation of the potential of psychiatric nurses by giving participants the opportunity to verbalise their experiences and wishes and to be heard. In order for interventions in Appreciative Inquiry to be generative, the questions ought to have the following qualities: questions that are unexpected or unusual, questions that extract meaningful responses or reveal energy, questions that build relationships by encouraging discussions and finally questions that require participants to view reality in a different way (Bushe, 2007:6). I integrated these guidelines into the formulation of the questions and into the discussion phases of the small core group inquiries.

The fifth assumption shows that when individuals or groups are allowed to incorporate parts of the known or the past they will be more secure when they move to the unfamiliar or the future. I focused on previous positive and effective systems to provide workplace support in the discovery phase in order to incorporate positive parts of the past.

The sixth assumption correlates with the previous by stating that individuals or groups should carry the most excellent from the known or the past to the unfamiliar or the future. This assumption again correlates with the positive principle. I aimed to strengthen participants' recollection of the best experiences they had relating to workplace support by allowing them to complete naïve sketches before the small core group inquiries, asking participants to write a story or narrative concerning a peak experience at work that made them feel most supported.

The seventh assumption stresses the importance of differences in individuals or groups (Reed, 2007:28). I motivated every participant to contribute in order to give everybody a chance to be heard and to make participants aware of diverse experiences. The methods of data collection that I used, including the small core group inquiries with psychiatric nurses and the individual interviews with members of nursing management, also highlighted the differences in experiences and wishes between psychiatric nurses and nursing management.

The eighth assumption shows how our narratives or stories construct our reality. This assumption can be connected to both the constructionist and the poetic principles. I worked from a positive framework according to Appreciative Inquiry methods, asking constructive questions and, as a result, facilitating positive narratives and feedback from participants.

1.6.3 Methodological perspectives

The methodological question is directed to how or in what manner the researcher should go about to obtain knowledge (Polit & Beck, 2008:13). A qualitative design was used during this research. Fouché and Delport (2005:74) explain the characteristics of a qualitative design as holistic and in-depth with a flexible design. Polit and Beck (2008:14) provided the assumptions set out below with regard to the naturalistic design.

Reality is mentally constructed by individuals, and these many realities are subjective. This assumption of qualitative research correlates with the constructionist principle of Appreciative Inquiry which refers to the subjectivity of reality and the construction of individual realities through narratives. My objectives were to explore the unique experience and wishes of each participant regarding workplace support in order to understand the experiences of the participants. This correlates with the Appreciative Inquiry assumption of multiple realities.

Research findings result from the interactive process between the researcher and the participants. This assumption can correlate with the simultaneity principle of Appreciative Inquiry to some extent, which proposes that “inquiry is intervention” (Whitney & Trosten-Bloom, 2003:54). Interactions with the participants are thus central to my understanding of the experiences and wishes of the participants relating to workplace support, as it forms part of the intervention.

During the small core group inquiries I used a co-facilitator or a discussion leader in order to achieve triangulation and to facilitate the group discussions and the nominal group technique while I took field notes and drew the positive core maps. The discussion leader was skilled in the facilitation of the 4-D cycle of Appreciative Inquiry. The independent discussion leader and I used different communication techniques during feedback and interviews, like paraphrasing, questioning, interpretation and summarising in order to verify our understanding of the data. I will discuss the data collection methods in detail in chapter 3.

Subjectivity of the researcher is expected and the researcher becomes part of the process. Since I was employed at the mental health care setting where the research occurred, my own subjectivity was inevitable to some extent. Polit and Beck (2008:15) maintain that in order for the qualitative researcher to understand and interpret the voices of the participants, the researcher requires subjective interaction with the participants. In light of my own involvement and subjectivity I employed various triangulation techniques during the data collection and during the analysis process to verify my findings. I will discuss the triangulation techniques that were used during this research in chapter 2.

I used a holistic approach, in accordance with the Theory for Health Promotion in Nursing, which correlates with the wholeness principle of Appreciative Inquiry. I aimed to explore a wide range of experiences and wishes relating to workplace support during the data collection phase. I did this by not giving participants a formal definition of workplace support and by encouraging participants to think of different experiences and wishes that they felt were supportive.

The processes that the researcher uses are inductive in nature or generalisations developed from specific observations (Polit & Beck, 2008:13). Ideas thus emerge from the data collection and there is no hypothesis testing (Reed, 2007:53). The insight of participants transpires through the experiences of the participants, and this insight of participants correlates with the simultaneity principle of Appreciative Inquiry which Whitney and Trosten-Bloom (2003:54) define as “inquiry creates change”.

I used a flexible design. This correlates with an Appreciative Inquiry design that does not determine interventions before, but rather plans and formulates interventions in a flexible design as the project develops (Reed, 2007:54). Results of a qualitative design are context-bound. I used a contextual design aimed at psychiatric nurses from a specific private mental health care setting in Gauteng and did not aim to generalise the findings.

The information in this research comprised a narrative form. Participants conveyed their stories by writing naïve sketches, discussing and answering the questions during the one-on-one interviews, further explaining their stories during the feedback and discussion phase and by conveying their experiences to me during the individual interviews. A narrative is both a way of relating to and explaining experiences (Reed, 2007:145).

1.7 CLARIFICATION OF MAIN CONCEPTS

I discussed all the main concepts of the research that are presented in the title.

1.7.1 Appreciative Inquiry

Appreciative Inquiry incorporates two aspects, namely "appreciate" and "inquiry". Appreciate means to assess and encourage excellence in people and their surroundings, including strengths, successes and potential. It is also to recognise the life-giving factors in living systems (Cooperrider, et al. 2008:1). Whitney and Trosten-Bloom (2003:2) define the twofold meaning of the word appreciate as a performance of recognition and that of adding significance. They continue to define appreciate as the recognition of the best in individuals and the environment, as the recognition of life-giving energy, as the acknowledgement of power in the past and the present and to enhance value.

Inquire means to be open to and explore new capabilities and possibilities through suitable, purposeful and positive questioning (Cooperrider, et al. 2008:1). Inquiry also refers to a process of investigation and finding, to querying, to learning and to exploring (Whitney & Trosten-Bloom, 2003:2).

Cooperrider et al. (2008:XI) define Appreciative Inquiry as "a form of transformational inquiry that selectively seeks to locate, highlight and illuminate the life-giving forces of an organisation's existence". It is founded on the principle that systems are imagined and formed by those working in them (Cooperrider, et al. 2008:XI). Appreciative Inquiry is thus the collective exploration for the optimal in personal and organisational functioning. It explores a system at its optimal functioning and foresees and reinforces future potential (Cooperrider, et al. 2008:3). Bushe and Fraser (2007:30) however emphasise that Appreciative Inquiry is "not just about the positive", but about generativity through pursuing new ideas that will change the social construction of the truth.

I used Appreciative Inquiry both as a theoretical and methodological perspective in this research, focusing on appreciating the positive responses, successful systems or effective interventions of psychiatric nurses in relation to workplace support without disregarding the negative experiences and responses, as Appreciative Inquiry does not only focus on the positive responses. Participants were motivated and given the opportunity to think of new ideas in the dream phase of the core group inquiries.

1.7.2 Experience

Coetzee and Schreuder (2010:517) define **experience** as observation or direct involvement in events that forms the basis for understanding and comprehension.

Remen (cited in Whitney & Trosten-Bloom, 2003:70) explains that each individual experiences an event differently and that narratives are comprehension and not the event self. In this research, experience thus included participants' interpretations of what they have personally seen, heard, felt and been involved in concerning workplace support.

1.7.3 Private mental health care setting

Private mental health care setting is a health organisation that provides care, treatment and rehabilitation for mental health care users (Government Gazette, 2002). Private meaning that mental health care is offered for financial gain (Searl, 2007:151). In this research, private mental health care setting refers to a private psychiatric clinic in Gauteng with a client capacity of 150 beds, with a short-term treatment programme offering treatment, care and rehabilitation for profit.

1.7.4 Psychiatric nurse

Psychiatric nurse is a registered nurse who has been qualified to provide mental health care, treatment and rehabilitation services to mental health care users (Government Gazette, 2002).

In this research it referred to a psychiatric nurse registered with the South African Nursing Council, who is providing mental health care to users and who is permanently employed in a private mental health care setting. All the participants in this research were psychiatric nurses, including participants in the small core group inquiries and participants from nursing management with whom I conducted individual interviews. Psychiatric nurses that formed part of nursing management included middle and senior nursing management. I discussed the inclusion criteria of participants in chapter 2.

1.7.5 Workplace support

Workplace support in this research means all the different interventions that can be

implemented by management at the place of work. Interventions can be in the form of establishing group cohesion, providing a good working environment, as well as assistance and encouragement from peers and supervisors (Booyens, 2008:364).

1.8 RESEARCH DESIGN

I used a qualitative design which was exploratory, descriptive and contextual, following an Appreciative Inquiry approach. Polit and Beck (2008:763) define qualitative research as an investigation that is holistic and in-depth through narratives, with a flexible design. I will describe the research design in more detail in chapter 2.

1.9 RESEARCH METHODS

In chapter 2 the research methods used are discussed in detail, including the research setting, a private mental health care setting and the selection of participants, which was purposeful sampling involving psychiatric nurses and members of nursing management.

The data collection was conducted using an Appreciative Inquiry approach and included naïve sketches, one-on-one interviews between participants, feedback and a group discussion, positive core maps, field notes, reflective interviews and individual interviews with members of nursing management. A discussion leader co-facilitated the small core group inquiries. I used an interview schedule (addendum E) during the small core group inquiries where psychiatric nurses conducted one-on-one interviews with each other (Whitney & Trosten-Bloom, 2003:116) and used the same interview schedule for individual interviews with members of nursing management (Reed, 2007:80).

I only employed the first two stages of the 4-D cycle, namely the discovery phase and the dream phase, as previously justified in paragraph 1.6.2.1, Appreciative Inquiry.

I used two data analysis methods, namely the nominal group technique and open coding. See the table summarising the data collection and data analysis methods in chapter 2.

1.10 METHODS TO ENSURE TRUSTWORTHINESS

I used the standards described by Lincoln and Guba (cited in Polit & Beck, 2008:539-540) as criteria to ensure trustworthiness in this research, namely credibility, dependability,

confirmability, transferability and authenticity. I will discuss these methods in detail in chapter 2.

1.11 ETHICAL CONSIDERATIONS

The ethical considerations relevant to this research were described according to the model of Burkhardt and Nathaniel (2002), namely autonomy, beneficence, non-maleficence, veracity, confidentiality, justice and fidelity. I also used the Declaration of Helsinki. I will discuss these ethical considerations in more detail in chapter 2.

1.12 SIGNIFICANCE OF THIS RESEARCH

Reed (2007:107) describes the significance of Appreciative Inquiry research by referring to the transformative nature of a discussion concerning peak past experiences. I envisioned that the use of Appreciative Inquiry as a research approach in this research will enhance collaboration of psychiatric nurse practitioners and stakeholders by providing psychiatric nurses with a voice regarding their experiences of and wishes for workplace support, and ultimately facilitate the promotion of the mental health of psychiatric nurses.

Participants had the opportunity to be empowered and to develop themselves beyond the parameters of the research related to their engagement in the Appreciative Inquiry process (Reed, 2007:107).

Additionally, a contribution will be made with regard to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice. Finally the mental health of psychiatric nurses can be promoted by the implementation of the recommendations discussed in chapter 4.

1.13 OUTLINE OF CHAPTERS

Chapter 1: OVERVIEW OF THE RESEARCH

Chapter 2: RESEARCH DESIGN AND METHODS

Chapter 3: DISCUSSION OF THE FINDINGS AND LITERATURE CONTROL

Chapter 4: JUSTIFICATION, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

1.14 SUMMARY

In this chapter, I highlighted the need of psychiatric nurses for workplace support in order to keep their lamps burning by promoting their mental health. I clarified the purpose and objectives of this research in terms of exploring and describing the experiences and wishes of psychiatric nurses regarding workplace support in order to propose recommendations regarding workplace support.

Following the background of the research, I discussed the problem statement, the research questions and the objectives of the research. I deliberated on the paradigmatic perspectives relevant to this research, including the Theory for Health Promotion in Nursing as the meta-theoretical perspective and Appreciative Inquiry as the theoretical perspective. The methodological perspectives were discussed. I also clarified the main concepts that are presented in the title of this research. Finally, I discussed the significance of this research on workplace support.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

In this chapter I will discuss the research design and the research methods I used during the research on the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. I will also discuss the qualitative, explorative, descriptive and contextual design I used for the research and elaborate further on Appreciative Inquiry approach, focussing on the discovery and dream phases.

I will explain the research methods in terms of the research setting, the selection of participants, the data collection and the analysis methods. Additionally I will discuss the strengths and weaknesses of the research methods employed during the research process. The methods to ensure trustworthiness referring to credibility, dependability, confirmability, transferability and authenticity will also be discussed. Finally I will examine the ethical considerations of this research by referring to autonomy, beneficence, non-maleficence, veracity, confidentiality, justice and fidelity.

2.2 PURPOSE AND OBJECTIVES OF THE RESEARCH

The overall purpose for performing this research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

The objectives for the research were to:

- explore and describe the experiences of psychiatric nurses regarding workplace support in a private mental health care setting,

- explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting, and

- propose recommendations regarding workplace support with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice in order to promote the mental health of psychiatric nurses working in a private mental health care setting.

2.3 RESEARCH DESIGN

A research design is the overall strategy used by the researcher in order to address the research questions and to enhance the reliability of the research (Polit & Beck, 2008:65). I used a qualitative design which was exploratory, descriptive and contextual. I integrated an Appreciative Inquiry approach into this design.

2.3.1 Qualitative design

Polit and Beck (2008:763) describe qualitative research as in-depth and holistic, with a flexible design. A qualitative research design involves an integration of data collection approaches, it is flexible, it aims to be holistic, it necessitates an engaged researcher who becomes the research instrument and finally it involves ongoing data analysis to determine strategies (Polit & Beck, 2008:219).

The interpretation of views given by participants is essential when conducting qualitative research, and information is optimised when the closeness between the researcher and the participants is minimised. The findings from qualitative research are the result of interaction between the researcher and the participants (Polit & Beck, 2008:15). The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

Reed (2007:54) suggests that the research design which most closely reflects an Appreciative Inquiry approach is a qualitative design, since Appreciative Inquiry deals with "naturally occurring phenomena" and uses a flexible design. A qualitative design also employs a flexible design and aims to obtain a holistic description of phenomena.

2.3.2 Exploratory design

Polit and Beck (2008:20) describe exploratory research as an enquiry into the nature of

phenomena. The aim of an exploratory design is to increase the understanding of a situation, an individual, a community or an experience (Fouché & De Vos, 2005:134). This correlates with the objectives of the research, namely to explore the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. My aim was to conduct an in-depth inquiry into the holistic experience of workplace support, correlating with the Theory for Health Promotion in Nursing.

Appreciative Inquiry as a research approach is also concerned with the interpretation and meaning of phenomena as well as with an understanding of the social world (Reed, 2007:65).

2.3.3 Descriptive design

Polit and Beck (2008:752) explain descriptive research as the accurate interpretation and portrayal by the researcher of the circumstances of phenomena and the characteristics of individuals or communities.

I used communication techniques, like paraphrasing, questioning, interpretation and summarising (Johnson, 2006:133) and member checking throughout the data collection process in order to ensure that my description and interpretation of the data obtained were accurate. (Please see 2.4.4.4, Role of the researcher). Polit and Beck (2008:758) describe member checking as a validating method employed through discussions with participants in order to assess the accuracy of the data collected. In order for me to accurately represent the experience and wishes of the participants, I provided some examples of the original data of the verbatim transcriptions, in the form of direct quotations, in chapter 3. Reed (2007:59) explains how an Appreciative Inquiry approach is concerned with describing or revealing phenomena.

2.3.4 Contextual design

Mason (2005:165) explains that a contextual design is guided by a holistic exploration in context. Reasons for using a contextual design might include looking for distinctiveness or wanting to understand a specific context (Mason, 2005:166). I described the experience of workplace support in a specific context, namely a private mental health care setting in Gauteng, and did not intend to make generalisations with regard to other settings. Psychiatric nurses in this context experience unique stresses due to the nature of the mental

health care users and the nature of mental health care provision. Psychiatric nurses in this specific context may require unique methods of facilitating workplace support. I provided additional details concerning the research context under the heading research setting and entrée in this chapter in paragraph 2.4.1. Reed (2007:65) also explains that an Appreciative Inquiry approach focuses on specific situations or settings and does not intend to generalise the findings.

2.3.5 Appreciative Inquiry approach

Appreciative Inquiry is more an approach than a distinct methodology. The relevant employment of Appreciative Inquiry can be determined by considering the purpose, the type of engagement and the inquiry approach employed (Whitney & Trosten-Bloom, 2003:24). Although it is complex to disconnect the intervention and research components of Appreciative Inquiry, I wanted to use it firstly as a research approach in order to explore and describe the experiences and wishes of psychiatric nurses relating to workplace support.

The first two phases of the 4-D cycle of Appreciative Inquiry which I implemented, namely the discovery phase and the dream phase, also correlate with research, as Reed (2007:124) also indicated by explaining that the discovery phase and the dream phase of Appreciative Inquiry "are strikingly relevant to research". All four phases of the 4-D cycle of Appreciative Inquiry can, however, be used to structure data collection by focusing and sequencing the data collection phase (Reed, 2007:124).

The focus was on a developing design, since Reed (2007:54) explains that planning interventions in Appreciative Inquiry is a continuous process as the research evolves and cannot be formulated beforehand. Appreciative Inquiry is flexible due to the responsive nature of the approach to events and contexts (Reed, 2007:123). This links to qualitative research based on the notion of an emerging design.

Appreciative Inquiry is the "exploration of what gives life to human systems when they function at their best" (Whitney & Trosten-Bloom, 2003:1). This move towards organisational and personal transformation is founded on the idea that change can be facilitated by asking questions and having discussions concerning successes, strengths, dreams and expectations (Whitney & Trosten-Bloom, 2003:1).

2.3.5.1 The 4-D cycle of Appreciative Inquiry

The method that is used to construct the potential of Appreciative Inquiry is the 4-D cycle. The 4-D cycle consists of the discovery phase, the dream phase, the design phase and the delivery phase, as shown in Figure 2.1, Diagram of Appreciative Inquiry 4-D cycle.

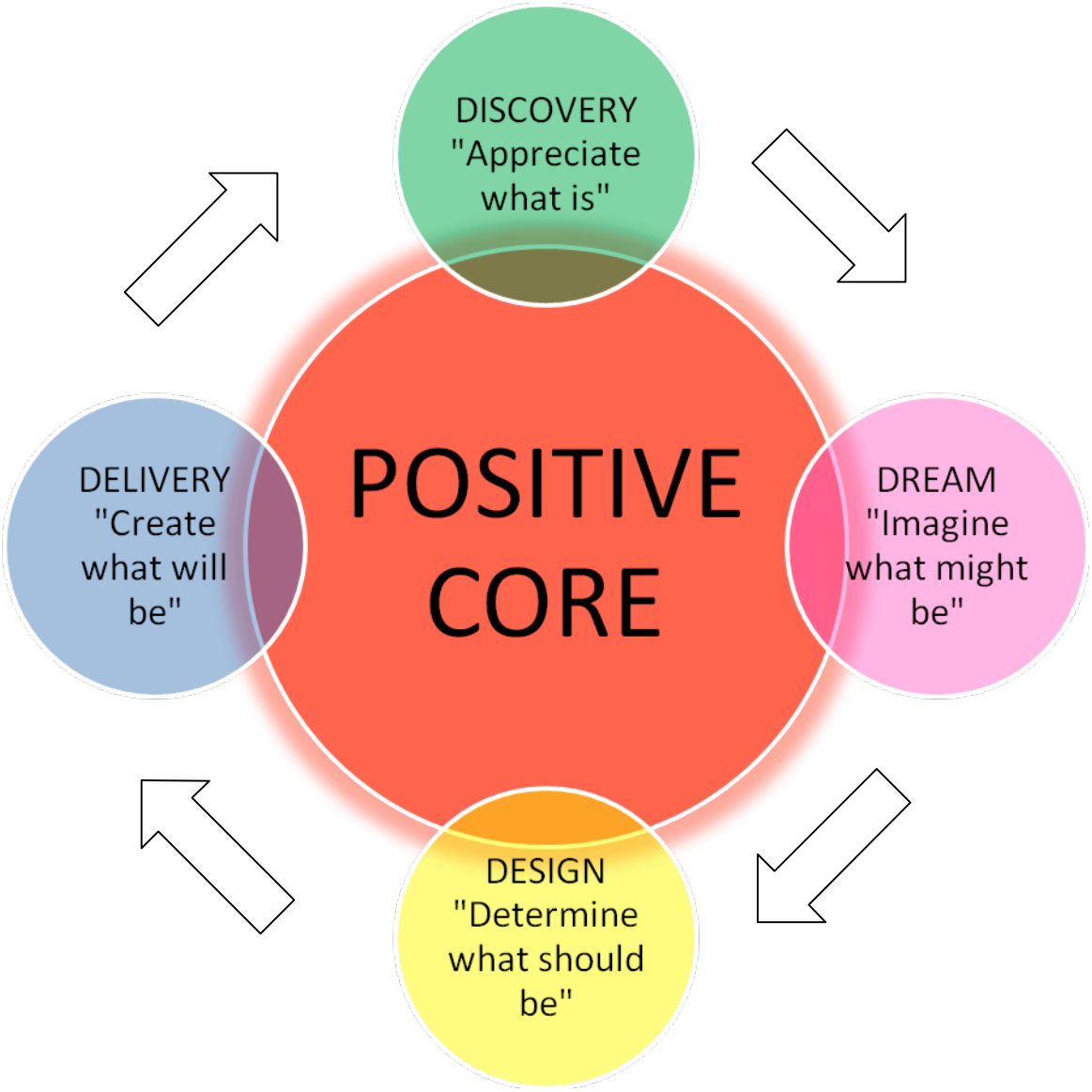

Figure 2.1 Diagram of Appreciative Inquiry 4-D cycle (Whitney & Trosten-Bloom, 2003:6)

Due to time constraints and the scope of this dissertation, I only facilitated the first two stages in the 4-D Cycle of Appreciative Inquiry, namely the discovery phase and the dream phase, to guide the inquiry process and to generate information. Reed (2007:124) provides examples of research that was done by concentrating on the first two stages of the 4-D cycle, namely the discovery and the dream phases, where an Appreciative Inquiry framework was used in conjunction with an organisational development programme. It is, however, possible to implement the latter stages of the 4-D cycle of design and delivery when doing research (Reed, 2007:124).

I felt that the discovery and dream phases could be linked to the assessment phase in the Theory for Health Promotion in Nursing, as both phases involve the collection of information, reflections on the past and deliberation relating to future action. The assessment phase in the Theory for Health Promotion in Nursing involves the collection and evaluation of information relevant to the internal and external environments, as well as the identification of facilitating and interfering factors (University of Johannesburg, 2009:8).

Although I only facilitated the first two phases of discovery and dream, I will discuss all four phases.

a) Discovery phase: "Appreciate what is"

The discovery phase is an all-embracing exploration to appreciate the best of the present situation, the life giving positive core. A positive core is the best of an organisation and its people (Cooperrider, et al. 2008:437). A positive core map is a visual representation of the resources, strengths and abilities of organisations (Cooperrider, et al. 2008:57).

Whitney and Trosten-Bloom (2003:7) suggest using one-on-one interviews in this phase. The one-on-one interviews involve face-to-face dialogue, usually conducted by organisational members after being trained in conducting appreciative interviews (Whitney & Trosten-Bloom, 2003:116). The one-on-one interviews comprise participants who interview each other in pairs using the provided interview schedule (addendum E).

The discovery process resulted in a detailed description of shared stories and serves to highlight collective organisational understanding. It also results in changes in the implementation of the following phases of the 4-D Cycle: the dream phase, the design phase and the delivery phase (Whitney & Trosten-Bloom, 2003:7-8).

In this phase Cooperrider (cited in Reed, 2007:35) suggests asking participants to describe a "peak experience" or "high point" regarding their experiences. A positive core can be expressed in various ways including narratives regarding achievements, best practices, competencies, assets, innovations, leadership capabilities, strategic opportunities, organisational achievements, organisational wisdom, positive emotions operational strengths, relationship resources, social capital, technical assets, values, vision, traditions, strength of stakeholders and capacities (Cooperrider, et al. 2008:35).

In the discovery phase, guided by the principles underlying Appreciative Inquiry as discussed under 1.6.2.2 (Whitney & Trosten-Bloom, 2003:8), I aimed to obtain a thick description of the positive core of the organisation (private mental health care setting).

I additionally drew a positive core map (addendum J) to ensure a thick description and to motivate participants to share narratives of their peak experiences relating to workplace support, in order to increase the combined understanding in the organisation relating to workplace support and to facilitate spontaneous transformation.

In the discovery phase the aim is to discover what provides energy to the individual or group. There is an assumption that there is energy and therefore I encouraged participants to discover this life-giving energy in their circumstances by carefully crafted questions. Cooperrider et al. (2008:103) express this phase as appreciating "the best of what is".

The request that was presented to all the participants for the completion of a naïve sketch is stated below:

- *Please write a story and tell me about a peak experience at work, when you felt most supported.*

The question that I asked participants (addendum E) in the discovery phase is stated below.

- *What actions from colleagues or supervisors makes you feel most supported at work?*

b) Dream phase: "Imagine what might be"

The dream phase is equally practical and creative. It accentuates the positive core and helps participants to imagine a constructive future of imagined results. In this phase

participants formulate their visions for the future. It is a joint exploration of dreams and possibilities (Whitney & Trosten-Bloom, 2003:8). Cooperrider (cited in Reed, 2007:36) suggests asking participants the following question: "what three wishes do you have for changing the organization?"

In the dream phase the facilitator motivates participants to dream unrestricted and innovative and to dream of possibilities that are immense and limitless and outside previous restrictions (Whitney & Trosten-Bloom, 2003:8). In the dream phase participants explore ideas of how the future could or might be. The dream phase develops from the first discovery phase. Cooperrider et al. (2008:103) express this phase as envisioning or "imagining what the world is calling for". In the dream phase the participants were encouraged to close their eyes and dream unrestricted.

My request (addendum E) to the participants in this phase is stated below:

- *Dream into the future and imagine this organisation giving you the best possible support at work.*

- *Please describe this dream.*

- *Please describe your wishes in order to realise your dream.*

c) Design phase: "Determine what should be"

In the design phase the participants construct future plans. This phase may include formulating provocative propositions or statements concerning what the individual or group still wants to aspire to, or objectives they still want to achieve. It is important to motivate participants to think in an assertive and positive way. Cooperrider et al. (2008:103) articulated this phase as co constructing or "determining the ideal".

d) Delivery phase: "Create what will be"

In the final or delivery phase energy progresses towards determining what is required to fulfil the provocative propositions. The researcher needs to motivate participants to reflect on detailed actions and processes, as well as to attain dedication from participants to deliver on their commitments. Cooperrider et al. (2008:103) define this phase as sustaining through

"empowerment, learning, adjusting and improvisation".

It is important to note that all the stages in the 4-D cycle are interconnected and that energy moves from one phase to the next in a circular movement. After completion of the delivery phase, the discovery phase and all the other follow-on phases can start all over again, as indicated in Figure 2.1 diagram of Appreciative Inquiry 4-D cycle.

2.4 RESEARCH METHODS

Polit and Beck (2008:758) describe research methods as the strategies and procedures of research. Reed (2007:112) suggests that there is a transformational focus from finding information in traditional research to generating or making information by applying Appreciative Inquiry. I will describe the research setting, the selection of participants, the data collection methods, the data analysis, measures to ensure trustworthiness and the ethical considerations of this research below.

2.4.1 Research setting and entrée

I conducted the research at a private mental health care setting in Gauteng. This mental health care setting has 150 beds with a short-term treatment programme. The majority of mental health care users admitted to the setting are diagnosed with mood disorders, eating disorders, substance abuse, personality disorders or anxiety disorders. The average period of treatment is two weeks and includes first-time admissions and readmissions. Since this is a short-term setting, some of the mental health care users are displaying acute psychiatric symptoms on admission, including loss of contact with reality and aggression.

There are seven wards with 18 to 24 beds in each ward. There is usually two to three staff members allocated to each ward, including one registered psychiatric nurse and one enrolled nurse. There is one care worker between one or two wards. The staff-to-patient ratio is between one to eight and one to 10, but Hanrahan et al. (2010:204) explains that there are "no empirical base" to establish the correct number of registered psychiatric nurses required for an inpatient psychiatric unit. Day staff members work on a fixed schedule of two to three days of 12 hours shifts with two days' rest in between, working every second Friday and every second weekend. Night staff members work seven nights of 12 hours each night, followed by seven days off duty.

There are currently 40 psychiatric nurses employed at this mental health care setting, as well as registered nurses (without psychiatry), enrolled nurses and care workers. These numbers include day and nigh personnel as well as members of middle and senior nursing management. Nursing management at this mental health care setting also uses nursing agency personnel on a daily basis. I did not include any agency personnel when I invited possible participants for this research, due to their irregular experience at this specific mental health care setting.

The functions of psychiatric nurses working at this setting include the administration of prescribed medication, the coordination of the daily programmes of clients, crisis intervention, nursing care activities, the formulation of nursing diagnosis and psychiatric nursing care for clients.

Psychiatric nurses participated in the data collection phase in their own time or during non-working hours in order not to disrupt the care of the mental health care users. Members of nursing management who participated in this research were all registered psychiatric nurses, one participant was at senior level and two participants were from middle nursing management. Senior nursing management refers to a psychiatric nurse who is involved with nursing service management, and middle nursing management refers to a psychiatric nurse who works with psychiatric nurses in the wards, performing administrative duties like audits of the files of mental health care users, performing in-service training and orientation and maintaining a supervisor position.

There are also other private agencies and individuals functioning in conjunction in order to provide client care, like psychiatrists, psychologists, occupational therapists, physiotherapists, cleaning agencies, catering services and gardening services. I previously worked in this setting for five years and is currently working at this specific mental health care setting on a temporary basis as a nursing agency member. I am known and well accustomed to the functioning of this organisation. I used this experience with the organisation to gain entrée, to invite participants and to formulate appropriate research questions. I will discuss the limitations regarding my prior engagement within this mental health care setting in paragraph 4.3.2.2 data collection method. Polit and Beck (2008:87) also suggest that the theme of the research should be in an area with which the researcher is familiar.

Before I conducted the research I contacted three gatekeepers, namely the Medical

Superintendent, Managing Director and the Nursing Service Manager of the private mental health care setting, in order to gain entrée (Polit & Beck, 2008:754). I had a preliminary meeting with the Nursing Service Manager to explain the research topic, the methods I proposed to use as well as a brief introduction to Appreciative Inquiry. I additionally provided the Nursing Service Manager with a copy of the proposal for my research, as well as examples of the information leaflet, consent form (addendum C) and the interview schedule (addendum E) I intended to use.

I also provided additional copies of the complete research proposal, with the information leaflet, consent form (addendum C) and interview schedule (addendum E), to the Medical Superintendent, the Managing Director and the Nursing Service Manager at this mental health care setting. The overall feeling at this meeting was very positive; however, the gatekeepers did have some questions later which resulted from the reading of my proposal. I responded to these questions by e-mail and still found the overall view from the gatekeepers to be positive. Questions focused on who I intended to invite to participate in the research, implications of data collection on client care and the process of data collection using an Appreciative Inquiry approach.

The Managing Director and the Nursing Service Manager were present at a second meeting I had with them in order to provide them with additional information regarding my proposed research and to answer any further questions that they had. I also needed to obtain written approval from the gatekeepers for my intended research at this meeting. I was amazed to find that, after my initial optimism, the gatekeepers harboured antagonistic feelings with regard to my research and that they were hesitant to grant me approval to continue with the research.

The gatekeepers at this setting verbalised that they felt positive about the theme of my research, but were hesitant regarding the response of their employees concerning the research, as well as the responses of participants during data collection. The gatekeepers were concerned that the research might influence the attitude of their employees negatively. Because the gatekeepers were unfamiliar with Appreciative Inquiry, I again briefly explained the methods to them, but left the meeting without written consent.

Reed (2007:121) provides some insight into possible reasons for gatekeepers to feel negative towards proposed Appreciative Inquiry research to be conducted. They might be apprehensive towards qualitative research due to their familiar ideas concerning quantitative

research requirements and results. Their previous experiences of research might have been negative as a result of being uninvolved or uninformed. Finally there might also have been disadvantageous consequences resulting from previous research, influencing participants or the organisation adversely.

My supervisors suggested another meeting with the Nursing Service Manager, during which it was agreed on that I would invite members of middle and senior nursing management to be individually interviewed by me, using the same interview schedule (addendum E) as for the core group inquiries. This corresponded clearly with what Reed (2007:70) suggested by arguing that invitations should be extended to as many participants as possible, including all the significant players in the organisation, in order to enhance acceptance, participation and to discover as many different views as possible.

The Nursing Service Manager of the mental health care setting where I did my research agreed to provide me with the necessary written consent (addendum B) after I have agreed to keep management informed about all the aspects of my research, including the invitation of participants, the data collection phases and the final findings.

2.4.2 Inclusion criteria for participants

I only invited participants who have been employed by the mental health care setting for at least six months prior to the research in order for them to have ample experience regarding workplace support in this specific setting. Participants must be registered psychiatric nurses in order to explore the specific experience and wishes of psychiatric nurses with regard to workplace support. Psychiatric nurses are also skilled in interview techniques, which were important during the one-on-one interviews that participants had with each other during the small core group inquiries. “Appreciative Inquiry interviews provide a vehicle that naturally draws on the interviewers’ skills” (Reed, 2007:115).

2.4.3 Selection of participants

I used purposeful sampling, which Polit and Beck (2007:763) define as a sampling method where participants are selected based on who will be the most informative regarding the topic of the research, namely workplace support in this research. The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experience and wishes of psychiatric nurses regarding workplace

support in a private mental health care setting. This search for substantial information regarding workplace support guided my selection and invitation of the participants.

All the participants in the research were registered psychiatric nurses, including participants who attended the small core group inquiries and members from nursing management with whom I conducted individual interviews.

Reed (2007:70) stresses that invitations to participants should be offered to all levels in the organisation in order to involve as many experiences as possible. I therefore invited members of nursing management who are registered psychiatric nurses to participate in individual interviews, as mentioned above, using the same interview schedule (addendum E) as for the small core group inquiry.

A small core group inquiry is a group that "conducts appreciative interviews" (Whitney & Trosten-Bloom, 2003:38-39). I felt that if members of nursing management were invited to participate in the small core group inquiries, it might lead to a feeling of uneasiness in participants and unwillingness to share information due to the presence of members from nursing management, or participants might have responded in a way that they felt members of management might approve of, influencing the credibility and authenticity of this research.

Members from the ethics committee also raised questions concerning the presence of middle and senior nursing management members at the small core group inquiries, and felt that it might influence the standard of information obtained during data collection. The data collection therefore involved the small core group inquiries and individual interviews with members from nursing management, which also enabled member checking and triangulation of the findings.

I am not aware of any coercion that formed part of the research; participation was voluntary in order to obtain authentic data of the experience and wishes of participants regarding workplace support.

Prior to the formal invitations to participate I focused on the building of rapport with potential participants. I previously worked in this setting for five years and I am currently working at this specific mental health care setting on a temporary basis as a nursing agency member, so this was achieved informally. (Please see 4.3.2.2, Data collection method, for possible limitations regarding my association with the participants.) Reed (2007:83) explained that if

the researcher is observed as being “part of the culture”, it can increase cooperation.

I obtained verbal consent from the nursing care manager to place an invitation to participate in my research in the tea room, since all potential participants were aware of my intended research. There were no reactions to this invitation.

Reed (2007:120) shared a description of the defence of participants of having no time to participate, thus explaining how some participants verbalise support for Appreciative Inquiry research, but do not contribute directly towards it in the end.

I continued to make personal invitations, where I gave information, explained confidentiality and answered questions. I provided willing participants with an information leaflet (addendum C) which I explained to them. I also used this opportunity to obtain written consent from each participant. Finally I asked the participants to complete the attached demographic information form (addendum D). The demographic information regarding the participants was significant with regard to the trustworthiness of the findings, as well as to describe the sample for possible repeat studies by other researchers. I treated all the personal information that could identify the participants as confidential, as will be further described in the paragraph 2.6, ethical considerations. Information obtained from the participants included their age, gender, race, psychiatric nursing experience and the period employed at the setting where the research took place.

2.4.4 Data collection methods

The data collection methods will be discussed in three parts, namely the naïve sketches, the small core group inquiries and the individual interviews with members of nursing management. The small core group inquiries included written answers on the interview schedule from the one-on-one interviews, transcribed feedback from the discussion phase, the positive core map, the nominal group technique, field notes and reflective interviews. See table 2.1 for a summary of the data collection and data analysis methods.

I used various types of data triangulation during the data collection, including naïve sketches, small core group inquiries, which included field notes, written answers on interview schedules, transcribed feedback from participants, positive core maps and information from the nominal group technique, and finally individual interviews with members of nursing management. Triangulation is defined by Polit and Beck (2008:768) as “the use of multiple

methods to collect and interpret data about a phenomenon, so as to converge on an accurate representation of reality". Data triangulation involves the use of multiple sources of data in order to validate the findings (Polit & Beck, 2008:543). Polit and Beck (2008:543) describe method triangulation as the use of "multiple methods of data collection about the same phenomenon". Method triangulation was achieved by inviting participants to complete the naïve sketches themselves, by participants conducting the one-on-one interviews with each other using the interview schedule (addendum E), by feedback from and discussion with participants, the results from the nominal group technique and by the individual interviews with members of nursing management. Time triangulation is data collection about the same phenomena at different times (Polit & Beck, 2008:543). Time triangulation was achieved by the completion of the naïve sketches before the core group inquiries, the two core group inquiries spaced approximately six weeks apart and by the final individual interviews with members of nursing management that stretched over the final month of the data collection. Person triangulation involves the collecting of data from different levels of individuals (Polit & Beck, 2008:543). Person triangulation was achieved by collecting data from psychiatric nurses as employees and from psychiatric nurses in managerial positions.

Table 2.1 Data Collection and Data Analysis Methods

DATA COLLECTION		
DISCOVERY PHASE		
Naïve sketch	Naïve sketch	Naïve sketch
SMALL CORE GROUP INQUIRY 1 (FOUR PARTICIPANTS)	**SMALL CORE GROUP INQUIRY 2 (THREE PARTICIPANTS)**	**INDIVIDUAL INTERVIEWS WITH NURSING MANAGEMENT (THREE PARTICIPANTS)**
Field notes	Field notes	Field notes
One-on-one interviews between participants (Discovery phase question)	One-on-one interviews between participants (Discovery phase question)	Individual interview (Discovery phase question)
Feedback from one-on-one interviews and group discussion	Feedback from one-on-one interviews and group discussion	
Positive core map	Positive core map	

DATA ANALYSIS		
Nominal group technique	Nominal group technique	
DREAM PHASE		
One-on-one interviews between participants (Dream phase question)	One-on-one interviews between participants (Dream phase question)	Individual interview (Dream phase question)
Feedback from one-on-one interviews and group discussion	Feedback from one-on-one interviews and group discussion	
Positive core map	Positive core map	
DATA ANALYSIS		
Nominal group technique	Nominal group technique	
Reflective interview with discussion leader	Reflective interview with discussion leader	
DATA ANALYSIS		
Open coding	Open coding	Open coding

2.4.4.1 Naïve sketches

A naïve sketch is notes or a short narrative by participants. Reed (2007:128) explains how Appreciative Inquiry studies sometimes invite participants to provide written accounts on the research subject, with the benefit of reflection time and the opportunity for participants to share their narratives in ways with which they feel comfortable. Reed (2007:128), however, cautions that participants might not engage or understand the research due to the absence of face-to-face interaction with the researcher. I explained the research and the naïve sketch to possible participants before obtaining written consent from them to participate in the research.

I also provided participants with my contact details in the participant information leaflet and consent form (addendum C) and encouraged participants to contact me if they had any questions regarding participation in the research or the completion of the naïve sketch.

The naïve sketches formed the first step in the data collection process, before the discovery phase question of the small core group inquiries, and were only completed by all the participants in this research. I requested all the participants to complete the naïve sketches in their own time, before the core group inquiries and before the individual interviews with members of nursing management.

The completion of the naïve sketches in the participant's own time had a dual function. Firstly the time frame of the data collection sessions was limited and secondly I did this in order for participants to conceptualise and reflect on the theme of workplace support without compromising the value of interaction with the researcher, since the naïve sketches were followed by either a core group inquiry or an individual interview. Participants would be invited to tell me in writing, in narrative form, about a peak experience at work when they felt most supported.

The request to facilitate the completion of the naïve sketch is stated below.

- *Please write a story and tell me about a peak experience at work, when you felt most supported.*

I collected the completed naïve sketches from participants before each small core group inquiry and before the individual interviews with members of nursing management. I provided an example of one completed naïve sketch in addendum K.

2.4.4.2 Small core group inquiries

Whitney and Trosten-Bloom (2003:38-39) define a small core group inquiry as a group that "conducts appreciative interviews" and suggest using a core group inquiry when working on a smaller scale, from five participants, and with time restraints. During the data collection phase of this research I facilitated two small core group inquiries on two different occasions consisting of four and three participants respectively.

The small core group inquiries were structured around one-on-one interviews which participants conducted with each other in groups of two, using an interview schedule (addendum E). Whitney and Trosten-Bloom (2003:116) further define one-on-one interviews as "face-to-face dialogue" or as a mutual process where two individuals interview each other consecutively, and it is usually conducted by members from the organisation.

I decided to implement two separate small core group inquiries in order to give all potential participants from all the different shifts equal opportunity to attend the data collection without interrupting the care to the mental health care users. I additionally conducted three individual interviews with members of middle and senior nursing management who were also psychiatric nurses and who met the inclusion criteria for participants as described in

paragraph 2.4.2.1.

The limited number of participants in the core group inquiries could be attributed to the fact that some participants who were invited were unwilling to take part in the research due to the fact that data collection occurred in their own time, some invited participants were not interested and some verbalised that they felt uneasy regarding the theme of the research. There were participants who were invited but were unable to attend the small core group inquiries on the arranged dates.

I was confident that data saturation was achieved despite the limited number of participants, since themes were repeated and no new information had been added to the data. The discussion leaders, my supervisors and the independent co-coder confirmed that data saturation has been achieved. Polit and Beck (2008:765) define saturation as "the collection of qualitative data to the point where a sense of closure is attained because new data yield redundant information". Conversation or dialogue, even between two members of the organisation, can be significant. Language is described as a design tool and dialogue as the process, with the purpose to express creativity and to realise dreams (Whitney & Trosten-Bloom, 2003:198).

Cooperrider et al. (2008:115) stress the importance of keeping to a planned time schedule. I prepared a complete time schedule (addendum F) for the core group inquiries beforehand and acted as the timekeeper during the two core group inquiries. Cooperrider et al. (2008:152) define the function of the timekeeper as the individual who ensures that the group sticks to the allocated time and who makes the discussion leader aware of the remaining time.

The data collection, which was structured as a small core group inquiry, took place at the specific private mental health care setting where psychiatric nurses were employed. The data collection phase lasted approximately four hours, including a tea break of 30 minutes.
It was a cold winter's morning when I went to the mental health care setting where I did the data collection. In the conference room I prepared the setting by organising seven chairs in two rows facing a white board. I also arranged two pairs of chairs in different corners of the room with clipboards, pens and the complete interview schedule for each of the four participants. I sat for a moment, carefully contemplating the day ahead, when the independent discussion leader arrived.

The discussion leader was an independent researcher on the first occasion and my supervisor on the second. The discussion leader ensures that each participant who wants to share their thoughts is heard and takes care that the group finishes in the allocated time frame (Cooperrider, et al. 2008:152). The function of the discussion leader, who acted independently and thus objectively, was twofold. The first was triangulation and the second was to facilitate the feedback from participants while I drew the positive core maps (addendum J) in order to ensure that all the emerging themes were identified and visible on a white board before the implementation of the nominal group technique.

The discussion leader and I had an interview to clarify each other's expectations for the day. My expectation of the discussion leader was that she would use communication techniques to obtain descriptions of the experiences and wishes of participants regarding workplace support when they gave feedback during the discussion phase of the data collection. I also expected her to substantiate the information and identified themes with the participants.

The discussion leader also facilitated the nominal group technique to confirm and categorise identified themes according to priority. Strydom (2005:419) suggest the use of the nominal group technique in a group with less than 10 members in order to prioritise the opinions of people regarding a challenge. The facilitation of the nominal group technique served a dual function, namely as a way of performing member checking and as a data analysis technique by identifying themes that were important for the participants. Polit and Beck (2008:758) describe member checking as a validating method employed through discussions with participants in order to assess the accuracy of the data collected.

Participants started arriving, looking a bit apprehensive, which I attributed to my own anxiety on the one hand and to the new situation on the other. Participation always demands time and energy from participants, which could make them feel hesitant to participate (Reed, 2007:21). It was this uncertainty of what to expect or what amount of effort I would expect from them that could have made participants apprehensive. This could possibly been alleviated if I had given participants more information regarding the purpose and the structure of the data collection during the invitation phase.

During the first core group inquiry we started an informal discussion while waiting for the other participants to arrive, and soon the formal prearranged seating naturally changed into an informal circle. The discussion leader suggested that we leave the chairs in this circle since it is a significant part of the interaction process. At the second inquiry I arranged the

chairs in a circle from the start. Two participants arrived late at the first inquiry and one participant who had given consent did not arrive at all during the second inquiry, which left me feeling agitated. Reed (2007:121) cautions that the researcher should expect reluctance from participants.

I formally started the relationship phase of the small core group inquiry with introductions. I explained the purpose of the small core group inquiry to the participants, namely to collect data concerning their experiences and wishes relating to workplace support. I elaborated but did not actually define workplace support. I wanted the personal views of the participants regarding workplace support, and also wanted to motivate participants to explore a wide range of experiences relating to what they experienced as being supportive in their workplace.

I encouraged participants to reflect on their experiences regarding workplace support. I also explained the purpose of the research to the participants in terms of exploring their experiences and wishes regarding workplace support and proposing recommendations in order to promote their mental health. I emphasised that this research was also being conducted to empower psychiatric nurses by giving them an opportunity to be heard, by voicing their needs of support, as well as to dream and to verbalise their wishes regarding workplace support. A core group inquiry "establishes a base of enthusiasm" (Whitney & Trosten-Bloom, 2003:40).

I additionally explained my selection criteria to the participants, namely that they were psychiatric nurses experienced in receiving and giving workplace support in this specific setting and that they are also skilled in interview and communication techniques, all of which was needed for this specific method of data collection. I confirmed that I would make a copy of the final research findings available to management at this mental health care setting, as well as to the participants.

I shortly clarified the ethical considerations concerning this research. I confirmed that I had received written consent from the ethics committee of the University of Pretoria (addendum A), as well as written consent from all the relevant gatekeepers at this mental health care setting (addendum B). I explained confidentiality to the participants, but stated that although confidentiality is guaranteed outside the data collection sessions, it is difficult in a group setting. I requested participants to treat the information obtained during the small core group inquiries as confidential. According to Polit and Beck (2008:181), it is difficult to assure

anonymity in qualitative research due to the researchers' involvement with the participants. The participants did sign consent for the use of a digital voice recorder, but I again emphasised that I would be using a digital voice recorder during the feedback phase of the data collection in order to capture all the responses of the participants.

I conveyed to the participants that I had the idea to do research on workplace support, but found that there were already very effective mechanisms and systems in place to provide workplace support to psychiatric nurses employed at this mental health care setting. This became evident in the discovery phase when participants shared their narratives about their own peak experiences regarding workplace support.

I told participants how one of my supervisors introduced me to Appreciative Inquiry. This gave me the opportunity to view my research in a completely different light. I could now explore the peak experiences of psychiatric nurses regarding workplace support, making recommendations based on their wishes and what they experienced as being supportive. My research was thus aimed at exploring "what the situation entails" (Reed, 2007:VIII) and I encouraged them to share any information that they felt comfortable with.

I explained that Appreciative Inquiry was a form of transformational inquiry that selectively seeks to highlight the life-giving forces in an organisation and that systems are imagined and formed by those working in the organisation (Cooperrider, et al. 2008:XI).

I continued to define Appreciative Inquiry for the participants in terms of the meaning of the concept "appreciate", which is to assess and encourage the best in people, as well as the concept "inquiry", which is to explore new possibilities through purposeful and transformational questioning (Cooperrider, et al. 2008:1). I clarified the four phases of Appreciative Inquiry for the participants, namely discovery, dream, design and destiny, by comparing the phases to the nursing process, which was well known to psychiatric nurses participating. I mentioned that we were only going to implement the first two phases, namely that of discovery and dream, during the core group inquiry.

In order to clarify Appreciative Inquiry further for the participants, I highlighted a few assumptions of Appreciative Inquiry, namely the constructionist principle, the simultaneity principle, the anticipatory principle, the positive principle and the enactment principle (Whitney & Trosten-Bloom, 2003:54-55). To close my introduction and in order for the participants to conduct their one-on-one interviews with each other, I summarised some

interview and communication techniques which were already well known to psychiatric nurses participating. I briefly discussed paraphrasing, questioning, interpretation and summarising (Johnson, 2006:133).

Data collection during the small core group inquiries will be discussed under field notes, written answers on the interview schedule (addendum E), transcribed feedback from participants, positive core maps (addendum J), the nominal group technique and transcriptions from reflective interviews.

a) Field notes

Greeff (2005:298) describe field notes as a written description of what the researcher saw, heard and experienced during data collection. Field notes include the seating arrangements and the order in which participants speak in order to help in voice recognition during transcribing as well as the non-verbal behaviour of the participants (Greeff, 2005:311).

These observational field notes were supplemented by reflective field notes, including methodological notes, theoretical notes and personal notes. Polit and Beck (2008:406-407) define observational field notes as an objective description of events, reflective notes as reflections regarding the methods used, theoretical notes as reflections on "how to make sense" and personal notes as reflections on the feelings of the researcher.

During the first inquiry an independent discussion leader and my supervisor were present. They took continuous field notes of the proceedings. During the second inquiry my supervisor acted as the discussion leader and I took the field notes.

I was present at all times to observe the one-on-one interviews that participants conducted with each other, to make field notes and to answer the questions of participants regarding data collection, thus being in the field to witness the actions of the participants (Stake, 1995:8-9).

My theoretical field notes focused on the identified themes and the nominal group technique. Personal field notes included my awareness of the feeling of the participants after the discovery and the dream phases, as well as notes on my personal identification with the participants.

b) Written answers from one-on-one interviews

I resumed by clarifying the agenda of the day for the participants. I explained how pairs of two participants were going to conduct the one-on-one interviews with each other for 15 minutes, using the provided interview schedule (addendum E). I described how participants will be invited to give feedback on their answers as a group, followed by a discussion of the themes. This process would be repeated for the dream phase after the tea break. I read and explained the first question of the discovery phase to the participants. I checked whether participants had any questions before they began their interviews.

I allowed participants to divide into two groups according to their personal preferences. I provided each participant with an interview schedule (addendum E), a clipboard and a pen. I acted as group facilitator by selecting the questions contained in the interview schedule (Cooperrider, et al. 2008:131). During the first core group inquiry the four participants divided into two groups and during the second core group inquiry participants conducted their interviews in a group of three participants. During the one-on-one interviews that participants conducted in pairs I acted as timekeeper and observer while making field notes and answering questions from participants.

The interview schedule contained questions based on the first two phases of the 4-D cycle of Appreciative Inquiry, namely the discovery phase and the dream phase. Prior to these questions a lead-in statement was presented to the participants. A lead-in serves as an introduction to the affirmative topic, creating the tone for the inquiry and helping participants to reflect on the topic (Whitney & Trosten-Bloom, 2003:150). The lead-in statement is stated below.

- *When our organisation is functioning at its best, it offers diverse methods of workplace support to us.*

This lead-in statement was followed by the first question. The discovery phase question is stated below.

- *What actions from colleagues or supervisors makes you feel most supported at work?*

Participants interviewed each other one-on-one for approximately 30 minutes in accordance with the interview schedule (addendum E). Participants wrote down the answers to the

questions on the interview schedule during their interviews.

It was interesting to note that during the one-on-one interviews that participants conducted with each other, the dynamics shifted from an initial meticulous following of the interview schedule and interviewing to a lively discussion and interaction between participants.

I ensured that participants had sufficient time to complete their interviews by checking on each pair and asking them whether the time was sufficient and whether they completed their interviews, while still keeping to the time schedule (addendum F). Participants then returned to the circle of chairs to give their feedback, using their completed interview schedules.

c) Transcribed feedback

Participants from the first core group inquiry were initially unsure how to proceed and the discussion leader replied that they can share in any way that made them feel comfortable. The first participant started to read her answers from the interviews, but soon that also changed into a lively discussion with all the participants contributing.

A short discussion of the identified themes followed in order for the discussion leader to clarify information with the group members. The discussion leader verified the content as well as her understanding of the information and themes by using communication skills like paraphrasing, reflecting, clarifying and summarising (Okun & Kantrowitz, 2008:75-76). The discussion leader would repeat a comment from a participant or an identified theme in order to check the accuracy or summarise information after some discussion among the participants. The discussion leader would also ask participants to elaborate or explain some detail during the feedback if some comment seemed vague or unclear.

I recorded the feedback, with the permission of the participants, commentary on the themes and the resulting discussion of the themes on a digital voice recorder. I later personally transcribed these recordings.

d) Positive core map

The discussion leader, in conjunction with the group, obtained consensus and identified emerging themes during the feedback. I functioned as the recorder, putting all the themes, as they emerged from the feedback of the participants, in writing on a whiteboard as a

positive core map (addendum J) for all the group members to see. Cooperrider et al. (2008:259) define the role of the recorder as the individual who writes the output of the participants on a chart. A positive core map is a visual illustration or summary of the resources, strengths and possibilities of the organisation (Cooperrider, et al. 2008:57). Whitney and Trosten-Bloom (2003:116) describe this as the most frequently used approach in Appreciative Inquiry.

Cooperrider et al. (2008:111) suggests that collecting illustrations of the positive core map is meaningful, which inspired me to take a photograph of each positive core map that was drawn and included in the data collected. I also included two photographs as examples of the positive core maps as addendum J.

e) Nominal group technique

The nominal group technique is a technique for a small group which involves the prioritising of needs or problems of a community (Strydom, 2005:419). In this research the nominal group technique was facilitated during the small core group inquiries, after each discovery phase discussion and again after each dream phase discussion, in order to prioritise the themes that were identified during the discussion phases.

After all the participants had shared their stories, the discussion leader summarised the identified themes on the positive core map. The nominal group technique was then facilitated where participants had the opportunity to make their choices regarding the five most important themes to them personally. The participants carried out the nominal group technique by putting up five stickers next to the five themes that they experienced as being the most important to them.

The implementation of the nominal group technique also served as member checking due to the fact that my interpretation of the information and identification of the emerging themes while drawing the positive core map were verified by participants by means of the performance of the nominal group technique.

During both core group inquiries the overall feelings of the participants at that stage of the process were very positive. Some participants stated that the questions regarding peak experiences from the naïve sketches and the discovery phase question regarding supportive actions from supervisors and colleagues, as well as the resulting discussion, made them

realise just how fortunate they were to work at that specific mental health care setting. This overall positive mood confirmed what Reed (2007:VIII) wrote about Appreciative Inquiry as being transformational.

While refreshments were served we discovered that during the first core group the participants had already completed their interviews for the dream phase as well. This could be ascribed to the fact that I provided participants with the complete interview schedule from the start and did not clarify the process clearly. I ensured that participants did not discuss both the discovery phase and the dream phase questions at the same time during the second core group by clearly explaining the process.

During the dream phase the discussion leader encouraged participants to close their eyes and dream into the future, wave an imagery magic wand and imagining that they experienced the best possible support at work.

The dream phase was facilitated by the inquiry statements below.

- *Dream into the future and imagine this organisation giving you the best possible support at work.*

- *Please describe this dream.*

- *Please describe your wishes in order to realise your dream.*

The participants gave feedback from their dream phase interviews in the same manner as during the discovery phase. The discussion leader facilitated the feedback while I recorded the emerging themes as a positive core map (addendum J). A discussion followed about the identified themes in this phase and the group again performed the nominal group technique in order to prioritise the main themes.

The overall feelings of the participants were still positive, but not comparable to their feelings after the discovery phase. Participants might have been tired at this point in time or the dream phase might have illuminated their dreams or wishes regarding workplace support, leaving them with a sense of apprehension. This uneasiness could have been the result of a feeling of being unfulfilled due to the fact that I only implemented the first two stages of discovery and dream.

I conducted the termination phase by evaluating whether the participants had any further questions. When the participants were asked how they experienced the morning, they all confirmed that it was positive to be reminded of all the things that were already supportive towards psychiatric nurses in this environment. They also verbalised that they felt as if they had a voice and would like to engage in small core group inquiries more often.

I reminded participants that I might refer back to them for member checking at a later stage. I also made myself available afterwards if participants needed support or referrals due to the sharing of information that caused them discomfort, like past experiences that made them feel less supported at work. No participant verbalised a need for support or contacted me after the data collection in order to verbalise their need for support.

f) Reflective interview

After the completion of each small core group inquiry the discussion leader conducted a reflective or debriefing interview with me, in order for me to formulate some additional reflective notes concerning the process of inquiry, the data obtained or the identified themes and the ethical considerations of the research. Reflective notes or field notes ought to include notes on the data collection methods used, the analytical aspects of the research and personal notes relating to the experiences or observations of the researcher during data collection (Polit & Beck, 2008:406-407).

Moderator debriefing is described as one of five types of debriefing and is aimed at identifying the initial perceptions of the researcher, unexpected findings, noteworthy statements by participants and to assess whether data saturation was achieved (Onwuegbuzie, Leech & Collins, 2008:5).

I felt that I had already achieved data saturation at this point after the two core group inquiry sessions, since many of the identified themes overlapped, and I was confident that possible unidentified themes did not warrant another core group inquiry. The discussion leaders confirmed that data saturation was achieved after the two small core group inquiries. The independent co-coder and my supervisors additionally confirmed data saturation. Polit and Beck (2008:765) define data saturation as the collection of data in qualitative research until no new information or themes emerges or until the impression of the researcher is that of closure. I still needed to conduct individual interviews with members of nursing management in order to hear as many different voices as possible relating experiences and wishes

regarding workplace support and to triangulate the findings.

I found the reflective interviews significant in relation to my own reflection regarding the ethical aspects, data saturation, the nominal group technique and the Appreciative Inquiry process.

2.4.4.3 Individual interviews with members of nursing management

After I had completed the two small core group inquiries, I invited members of middle and senior nursing management who were registered psychiatric nurses to be individually interviewed by me. I identified three willing participants and after I had given them a short description of the data collection process, I provided them with a consent form (addendum C), a demographic form (addendum D) and a naïve sketch to complete in their own time.

The completion of the naïve sketches beforehand would provide them with time to reflect on their experiences and wishes regarding workplace support before I conducted the interviews with them.

I conducted one interview at a private venue and the other two interviews at the private mental health care setting where I did my research. The interviews lasted between 30 and 45 minutes each.

I used the same inquiry statements (reflected in the interview schedule, addendum E) that I prepared and used in the small core group inquiries to facilitate the individual interviews, as stated below:

- *Please write a story and tell me about a peak experience at work, when you felt most supported.*

- *When our organisation is functioning at its best, it offers diverse methods of workplace support for us.*

- *What actions from colleagues or supervisors make you feel most supported at work?*

- *Dream into the future and imagine this organisation giving you the best possible support at work.*

- *Please describe this dream.*

- *Please describe your wishes in order to realise your dream.*

I made field notes during the interviews and recorded the interviews on a digital voice recorder, with written permission from the participants, which I personally transcribed at a later stage.

I found the individual interviews with members of nursing management to be more complex. These individuals from nursing management were expected to be the support givers to psychiatric nurses employed by them. Information from the individual interviews with members of nursing management correlated with that from the core groups, but focused more on the support received from colleagues who were also in nursing management positions.

Participants from the small core group inquiries verbalised that they experienced their fellow psychiatric nurses, as well as members from nursing management, to be supportive. Participants from the small core group inquiries focused more on the effectiveness of systems, which was not so evident during the interviews with nursing management. The individual interviews did, however, provide me with insight into the experiences and wishes regarding workplace support from the point of view of the nursing managers.

2.4.4.4 Role of the researcher

The character of the relationship between me and the participants was crucial to both the data collection and the data interpretation phases of this research. It was therefore important to me to have the assistance and support of the participants (Burns & Grové, 2007:76). Burns and Grové (2007:77) continue to describe the interactive influence of the researcher and the participants, which is an expected aspect in the qualitative research process and important for my understanding and interpretation of their described experiences.

Henning, Van Rensburg and Smit (2004:81) illustrate how the researcher "becomes the instrument of observation" by integrating that which is heard, seen, sensed or read into a translation of that which is present in the environment of the researcher. I also analysed the data more than once (Henning, et al. 2004:82); firstly by observation during data collection

and field notes, as well as by facilitating the nominal group technique, and secondly by performing open coding by referring to the written transcriptions of feedback and photographs of the positive core maps (addendum J).

In the discovery phase I formulated the interview questions, the interview schedule and the interview plan and inquiry strategy. I also coached participants to conduct Appreciative Inquiry interviews and share narratives of best practices (Whitney & Trosten-Bloom, 2003:149).

I needed to decide which participants would be a rich source of information in the discovery and dream phases and I assured that the voice of every participant was heard. I also needed to decide what the outcome of the discovery and dream phases had to be and how participants would reveal or share their particular dreams (Whitney & Trosten-Bloom, 2003:183).

2.4.5 Data analysis method

During the data analysis phase I used two different techniques in order to analyse the available data. The reason for the use of two different techniques was firstly due to the two different ways of data collection that occurred and secondly to achieve analysis triangulation, which is achieved by using two analytical techniques on the same data (Polit & Beck, 2008:548). See paragraph 2.4.3, table 2.1, data collection and data analysis methods.

The available data consisted of the written naïve sketches of all the participants, written answers on the interview schedules from the one-on-one interviews during the small core group inquiries, transcriptions of recorded data from feedback of the participants during the discussion phases of the small core group inquiries, photographs of the positive core maps that indicate the nominal group technique which were drawn by me in conjunction with the participants, field notes taken by my supervisor and myself during the core group inquiries, transcribed voice recordings from the debriefing or reflective interviews with the various discussion leaders after the core group inquiries, as well as transcriptions and written answers from the individual interviews with members of nursing management.

Data analysis already began with the identification of themes and the positive core map that I drew during the data collection phase. The facilitation of the nominal group technique during the core group inquiries also assisted in the identifying and conformation of themes

by the participants. After the two small core group inquiries I sorted and categorised the identified themes recorded on the positive core maps according to the preference of the participants, as indicated during the nominal group technique.

I used the technique described by Tesch (1990:142), namely an inductive, descriptive approach to data analysis. I used open coding to sort and categorise themes from the transcriptions of the discussion phase and the individual interviews. Polit and Beck (2008:760) define open coding as a description of the themes from narrative data. After personally transcribing the voice recordings from the two core group inquiries and the three individual interviews, I read through the data while reflecting on and noting clusters of themes in order to discover an overview of the content.

I organised the data manually by using highlighter pens in different colours. I made a list of all the themes, including those from the nominal group techniques, and arranged the themes into categories after naming each theme and coding each topic or theme with an explanatory sentence. I compared and noted interrelationships between themes, recoding some themes as I analysed them.

In keeping with the symbol of the thorn tree (discussed later under the central storyline in paragraph 3.3.1) I described the themes as branches and the categories as leaves and buds. The categories described as leaves emerged during the discovery phase questions and the categories described as buds emerged during the dream phase questions of the small core group inquiries and the interviews and it resembled the wishes of psychiatric nurses regarding workplace support.

I gave copies of these categories, along with the transcriptions of the recorded data and positive core maps, to an independent co-coder for verification of the identified themes. I also provided the independent co-coder with a work protocol (addendum I) to ensure that the same method of inductive, descriptive design to data analysis was used. Polit and Beck (2008:551) stress the importance of verification of data and the analysis process by thoroughly confirming and checking the data and the analysis thereof. I had a discussion with the co-coder where consensus was reached with regard to the identified themes. This process also ensured analysis triangulation, which involves the validation of the meaning of qualitative data (Polit & Beck, 2008:548).

After the independent co-coder has confirmed the themes that were identified, she

suggested that it fits perfectly in the Theory for Health Promotion in Nursing. I went back to all the data and categorised the confirmed themes again according to the internal and external environments as defined by the Theory for Health Promotion in Nursing. Since it is difficult for a qualitative researcher to describe the inductive process used to come to a conclusion (Polit & Beck, 2008:530), I provided some examples of the original data in chapter 3 to support my findings. Finally, I conducted a literature control, integrated into chapter 3.

2.5 METHODS TO ENSURE TRUSTWORTHINESS

I used the standards described by Lincoln and Guba (cited in Polit & Beck, 2008:539-540) as criteria to ensure trustworthiness in this research, namely credibility, dependability, confirmability, transferability and authenticity.

2.5.1 Credibility

Credibility is to validate that the investigation was performed in such a way as to describe the concept of workplace support accurately and sufficiently (De Vos, 2005:346). The credibility of the research was enhanced by using more than one data source, namely the naïve sketches, the written answers from the one-on-one interviews of the participant, field notes, the transcriptions of the feedback in the group phase, photographs of the positive core maps (addendum J) and transcriptions of the individual interviews with members of nursing management.

The participants were all registered psychiatric nurses, competent in interview and communication skills. Interview schedules (addendum E) were provided to guide participants through the interviews. I conducted a brief introduction to Appreciative Inquiry and interview techniques during the small core group inquiries. I gave participants sufficient time to complete their one-on-one interviews during the small core group inquiries and afforded them an opportunity to add information during the group discussions of the small core group inquiries. I made field notes during the interviews and while participants reported back on their interviews, noting any additional information.

Investigator triangulation is the use of more than one researcher to enhance validity (Polit & Beck, 2008:756). Investigator triangulation was achieved by the inherent method of Appreciative Inquiry used, namely the one-on-one interviews and the presence of a

discussion leader. Data collection also occurred on two different occasions, namely the small core group inquiries and the individual interviews with members of nursing management, which resulted in data triangulation. Triangulation was finally used in the analysis stage by means of the presence of a co-coder who verified the findings of the identified themes (Polit & Beck, 2008:543).

I used two different types of data analysis, namely the nominal group technique and open coding in identifying the themes. I used member checking by the performance of the nominal group technique, after each group discussion of the small core group inquiries, in order to enhance the credibility of the research. Participants were each given the opportunity to identify the five most important themes to them personally.

Researcher credibility reflects on the researcher as the data collection instrument and the producer of the data analysis process, thus emphasising researcher qualifications, reflexivity and experience (Polit & Beck, 2008:550). I completed a research methodology programme prior to conducting this research. Both supervisors of this research hold a Doctoral degree and have extensive experience in nursing research. The researcher is a psychiatric nurse, skilled in reflection-in-action, as well as reflection-on-action (Brown, Esdaile & Ryan, 2004:121). Reflective thinking is the careful consideration of any supposed form of knowledge (Brown, et al. 2004:122). I was aware of my own reflective activities during all the stages of the research. I kept field notes to capture additional information and personal reflections on emerging themes and the processes that transpired.

2.5.2 Dependability

Polit and Beck (2008:751) define dependability as the criterion for the evaluation of the integrity of qualitative research, referring to the stability of the data over conditions and time. I ensured the dependability of this research by describing and documenting all the phases and methods used in the research comprehensively and by making all documents available for an audit trail if required. All transcriptions and documents will be kept in the Nursing Department for 15 years. I also provided an example of a completed naïve sketch (addendum K), as well as photographs of two positive core maps (addendum J).

The variation in the themes from the small core group inquiries and the themes from the individual interviews with managers might be ascribed to the fact that psychiatric nurses from the small core groups viewed themselves as the support recipients while members of

management were seen as the support givers.

2.5.3 Confirmability

Polit and Beck (2008:750) define confirmability as the criterion for the evaluation of integrity in qualitative research, referring to the neutrality or objectivity of the collected data and the interpretation thereof. Polit and Beck (2008:539) continue to describe this objectivity as the "potential for congruence between two or more independent people" regarding the accuracy, meaning and relevance of the data.

I will discuss the quality enhancement strategies relating to confirmability that were used in this research according to Polit and Beck (2008:544). I used various methods of triangulation, as discussed under credibility, in order to achieve the confirmability of this research, including investigator triangulation, method triangulation, data triangulation, time triangulation and analysis triangulation. I described the steps used in the research process, including the data collection and analysis methods used in this research. I used an independent co-coder to verify the findings. I also conducted a literature control to verify the findings and provided examples of the original data collected in order to represent the voices of the participants. All documentation relevant to this research will be kept in the Nursing Department for 15 years and will be available for an inquiry audit if required.

2.5.4 Transferability

Transferability means the applicability of the findings from one research to other circumstances (De Vos, 2005:347). Although transferability was not my aim due to the contextual design I used, I did indicate selected transferability of the research by ensuring a dense description of the data and by giving examples of the original data in chapter 3. During the sampling phase, which was purposeful sampling, I aimed to invite participants who were a possible rich source of information. Finally, I performed a literature control in chapter 4 in order to recontextualise the findings of the research in existing literature and to clarify the inference made.

2.5.5 Authenticity

Authenticity is defined by Polit and Beck (2008:748) as the extent to which an impartial qualitative researcher demonstrated a wide range of experiences in the data and analysis. I

was familiar with the mental health care setting where the research took place, which added to the authenticity of the research. The nature of the Appreciative Inquiry method used, namely starting with the naïve sketches, followed by the one-on-one interviews, which led to feedback and a discussion, before drawing a positive core map, all contributed to my comprehension of the data and the authenticity of the final findings.

The use of communication techniques like summarising and questioning by the discussion leader, facilitation of member checking or the nominal group technique and the additional individual interviews with members of management, all contributed to the authenticity of my research. I provided examples of the naïve sketches and verbatim transcriptions of the small core group inquiries and the individual interviews with members of nursing management, as well as examples of the positive core maps, in order to represent the voices of the participants in this research and to reflect on the reality of participants.

2.6 ETHICAL CONSIDERATIONS

Prior to conducting the research, I referred to the ethical principles for medical research involving human subjects of the World Medical Association Declaration of Helsinki (University of Pretoria, 2005) for guidance with regard to the ethical implications of the research. According to the Declaration of Helsinki, the researcher must demonstrate compliance with the ethical considerations.

I discussed the ethical considerations relevant to this research as described by Burkhardt and Nathaniel (2002), namely autonomy, beneficence, non-maleficence, veracity, confidentiality, justice and fidelity.

2.6.1 Autonomy

According to Burkhardt and Nathaniel (2002:41-42), autonomy means that individuals must be free to make choices with regard to issues in their own lives. This means that I showed respect for the participants, their personal goals, their dreams and their proposed plans during the data collection phase of the research. Participants in this research participated voluntarily and I allowed participants to divide themselves into pairs for the one-on-one interviews during the small core group inquiries in order to put them more at ease and to show respect for their autonomy.

The researcher demonstrated respect for participants and for the organisation as a system by obtaining informed and voluntary consent from the Managing Director of the mental health care setting (addendum B), as well as all participants involved in the research (addendum C). The participants had the option to withdraw from the research at any time if they required to, and no intentional coercion was used. Polit and Beck (2008:172) define coercion as threats of negative or positive consequences for participating in the research or for sharing information. The free-choice principle of Appreciative Inquiry also acknowledges the benefit of giving people autonomy.

2.6.2 Beneficence

Polit and Beck (2008:748) define beneficence as research that avoids harm to the participants and aims to increase the benefits that are offered to participants. Participants have the right to be free from harm and the right to be protected from exploitation (Polit & Beck, 2008:170-171).

The risks of research are justified by the potential benefits to the individual or the society, or the mental health care setting in this research. I made myself available to the participants for intervention or referrals after the core group inquiries if they felt the need for support after the data collection.

Possible risks and discomfort of this research could have been that some of the questions asked might have made the participants feel uncomfortable, but participants were informed that they need not share information if they did not want to. I was able to evaluate the impact of the data collection phase on participants during the feedback phase of the small core group inquiries. Possible negative effects might have included the sharing of negative experiences from the past and the emotions stemming from those experiences. Participants were also expected to travel to the venue once and to participate in their own time, approximately four hours, without compensation.

Possible benefits of this research included that participants might benefit directly by participating in the data collection phase because of the Appreciative Inquiry method used, which can be supportive in nature and can enhance collaboration of psychiatric nurse practitioners and management. The results of the research can enable better workplace support to psychiatric nurses in future by means of recommendations made with regard to organisational policy.

Liamputtong and Ezzy (2005:42) point out that owing to the narrative nature of qualitative methods, research can be inherently therapeutic. The small core group inquiry was therapeutic in itself by giving participants the opportunity to verbalise their experiences and wishes regarding workplace support. The mental health care setting at which the research took place can also benefit through the possible implementation of recommendations from the research, leading to a possible decline in absenteeism and personnel turnover.

The results of this research regarding workplace support in a private mental health care setting would be made available to all the participants and members of management on request.

2.6.3 Non-maleficence

Non-maleficence in this research meant not causing harm to the participants or the mental health care setting in any way (Burkhardt & Nathaniel, 2002:51). I obtained ethical approval from the Ethics Committee of the University of Pretoria before conducting the research (addendum A). I also obtained written consent from the management of the mental health care setting where the research took place, including from the managing director, the Nursing Service Manager and the medical superintendent (addendum B). I provided all participants with an information leaflet and consent form (addendum C) prior to the data collection phase. All the participants signed these consent forms before the data collection phase commenced.

Possible negative effects could result from the sharing of past negative experiences and the emotions associated with those experiences. I was able to evaluate the impact of the data collection phases on the participants during the feedback phase of the core group inquiries and during the individual interviews with members of management. I was also available for intervention or referrals after the small core group inquiries if participants needed counselling. Participants were made aware of my availability for intervention through the information leaflet that was handed to them prior to signing consent to participate in the research (addendum C). I am a psychiatric nurse who is able to evaluate and intervene, or alternatively refer participants, should any unwanted effects from the research be perceived.

The revealing of less effective ways of providing workplace support in the past by members of management from the mental health care setting may cause possible harm to the organisation. This can be overcome in the dream phase where participants suggest

alternative means of facilitating workplace support. I worked from a positive framework in referring to experiences by using the method of Appreciative Inquiry.

2.6.4 Veracity

I was honest regarding the subject, purpose, methods and results of the research when gaining entrée, obtaining consent from managers (addendum B) and participants (addendum C), as well as when communicating the results and the limitations of the research (Burkhardt & Nathaniel, 2002:51). The data collection phases included small core group inquiries where all participants could witness the discussion phases and information given.

2.6.5 Confidentiality

Polit and Beck (2008:750) state that confidentiality means that I protected the participants as well as the mental health care setting by signing an agreement to keep personal identifying information, as well as data linked to a specific participant, confidential. Although confidentiality is guaranteed outside the data collection sessions, it is difficult in a group setting. Participants were made aware of the data collection method and confidentiality before signing consent to participate through the information leaflet (addendum C). According to Polit and Beck (2008:181), “anonymity is almost never possible in qualitative studies”.

I gave participants the opportunity to divide themselves into groups to make them feel more at ease during the interviews. The only other parties that had access to the data or discussions about the research were my supervisors, the discussion leaders of the small core group inquiries and the co-coder. I signed confidentiality agreements with the discussion leader (addendum G), who also acted as the co-coder (addendum H).

Primary data, as well as documentation resulting from coding and analysis, will be kept under lock and key for 15 years in the Nursing Department.

2.6.6 Justice

Polit and Beck (2008:173) define justice as the reasonable and non-discriminatory treatment of participants as well as respect for their right to privacy. Although the demographics of this

research give the impression of bias due to the limitation in representation regarding sex and race, I invited all potential participants who fell in the inclusion criteria of participant selection in order to give them an equal chance to participate in the research. I demonstrated justice towards the participants and the mental health care setting by communicating the final findings of the research to all involved parties.

2.6.7 Fidelity

I demonstrated fidelity by keeping promises made towards the mental health care setting as well as towards the participants (Burkhardt & Nathaniel, 2002:59), for example, staying in the allocated time frame of four hours for the data collection sessions, communicating findings of the research and keeping confidentiality.

2.7 SUMMARY

In this chapter, I gave a detailed description of the research design as qualitative, explorative, descriptive and contextual. I discussed Appreciative Inquiry, explaining the first two phases of discovery and dream. I provided details of the research methods in terms of the research setting, the selection of participants, the data collection and analysis, as well as a discussion of the strengths and weaknesses of the research methods. I discussed methods to ensure trustworthiness and the ethical considerations for this research.