

Journeys into Caring Community

A Narrative Inquiry Into The Stories Of Adults' Experiences Of Engagement With A
Local Socially-Inclusive Christian Community Group

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ABSTRACT

There is a lack of literature specific to the longitudinal experiences of participants in socially-inclusive faith-based caring communities. Such communities often have participants who have suffered experiences of exclusion and marginalisation. There are implications from those experiences for improving participation and belonging not just in local communities but also society. The study was located within the bicultural context of a small town in Aotearoa New Zealand in a Caring Community under the umbrella of the Anglican Church. A narrative inquiry process was chosen to capture participants stories of coming to the Community, participating, and developing their own sense of belonging within the group. These stories were re-told and analysed using a process of narrative analysis. The values of the community embraced bi-culturalism, holism, a Christian ethos, equality and reduction of hierarchy. Structured conversations were held with seven adults who are participants of the Caring Community with results showing that they found it a safe and respectful place to be, where they can express their spirituality and develop mutually beneficial relationships. Common themes emerging from the resultant narratives included increased safety, belonging, family, identity, participation, progressive inclusion, cultural respect, and an increase in wellbeing that provides clues and indications to future practice and policy when providing assistance to marginalised groups, that is client-centred and owned. Additionally there are implications for generating inclusion and caring communities in more mainstream church communities for increasing holistic wellbeing and caring relationships.

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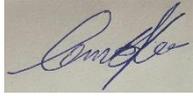
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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.



Signed: _____ Adrienne Kerr

Date: _____20/07/2017_____

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CONFIDENTIAL MATERIAL

In order to protect the anonymity of the particular community group of focus in this research, it is referred to as the “Caring Community” throughout. This convention is also applied to community documentation cited throughout the research. Copies of original community documentation can be requested via the researcher, Adrienne Kerr, using the email address: dabrewerton@gmail.com

Such requests will be forwarded to the Caring Community by the researcher.

CHAPTER ONE: INTRODUCTION TO THE INQUIRY

Hutia te rito

Hutia te rito o te harakeke

Kei whea te korimako e ko

Ki mai ki ahau

He aha te mea nui

He aha te mea nui o te ao

Maku e kii atu

He tangata, he tangata,

He tangata, hei!

If you remove the heart

Of the flax bush

From where will the bellbird sing?

If you say to me

What is the most important thing

In this world

I will reply to you

It is people, it is people,

It is people!

RESEARCH QUESTION AND SCOPE

The research question posed in this research is, ‘What are the narratives of adults who are part of a socially-inclusive Christian community group?’ This research uses a narrative inquiry approach to explore the experiences of adults in such a group. I am a participant of this particular group, which aims to provide a safe space for people to explore the needs they have, and make transformational connections. My reasons for undertaking this research fall into three categories; aims related to academia, aims related to the Caring Community, and aims related to wider society.

My academic aims for this research are to bring out and amplify the stories of marginalised people whose voices are often not heard in research, in order that their needs can be better met by organisations they

encounter, and so they can be better understood. To explore these participants' stories in an academic context is a personal response to the privileged space I hold. I find personal value, challenge, and growth through my own participation in the Caring Community, and a large part of that is due to the proximity I am in with other wonderful humans who share their stories and lives with me. I feel a sense of responsibility to these people to use my abilities and resources to explore our shared experiences in the world of decision makers.

My aim for this research that relates to the Caring Community is to first and foremost uplift and respect the values of the group. I am hoping to discover what worth, if any, there is of participation for people of this Caring Community. I want to see how the participants' experience of the Caring Community intersects with the rest of their lives. It is my intention to respectfully listen to the stories of participants, and to re-tell these stories; through this process I want to gain insight into the motivations, hopes and fears of these participants. I am hoping that these stories will shed light on why people come to the Caring Community, how they become engaged, and why they stay.

For the broader society I am hoping that this research will provide hope for people working in professional contexts where problems may seem so extensive or complicated that hope is hidden. This research may help to identify some flax-roots ways to promote biopsychosocial and spiritual health amongst vulnerable people groups. I am hoping that it may provide some insight into the ways that people who have chosen not to engage with formalised support services engage in alternative spaces. When people read this research it is my desire that they will get a sense of what it is like to be a part of this Caring Community. I want to explore the contribution that groups like the Caring Community can make to society. It is ultimately my hope that by bringing out the stories of a diverse group of people, we can positively alter the way we work with, be Church with, and provide services for, other people.

I wanted to explore the narratives to gain a deeper understanding of my fellow community participants, how they view participation in the community, and how the community intersects with the rest of their lives.

DEFINING THE STUDY

Stories, and the symbolic worlds they project, are not like monuments that men behold, but like dwelling-places. People live in them (Crites, 1971, p. 295).

This study explores the narratives of adults engaged in a specific socially-inclusive Caring Community in a small town in New Zealand. Their experiences were elicited and explored using a narrative inquiry approach to research. The research approach was designed to respect and enhance the values of the Caring Community (The Caring Community, 2015). Through this research, the curated narratives are gifted back to the participants, as well as to a wider audience to look through this window into the worlds of people gathered to support and encourage one another.

Over the summer of 2016-2017 seven adults volunteered to participate in this research around participation in a Caring Community group. Through a process of narrative inquiry, they shared their stories with me of their early life through to engagement with the community. The following are the results of this inquiry into those stories.

The phrases ‘socially-inclusive Christian Caring Community’ and ‘Caring Community’ are used interchangeably to refer to, and describe, the group of which these research participants are a part. These terms were selected to distinguish the group from the geographical community and to convey key aspects of the kaupapa of the group. When Kabeer (2005) studied citizenship around the world, she examined the values that ‘excluded people’ considered to be the components of ‘inclusive society’. She describes four core values that comprise inclusive society: self-determination, recognition, social justice, and a sense of horizontal solidarity with others. The Caring Community of this study articulates different values as their basis for relating to one another, however they paint a similar picture including inclusivity, non-judgementalism, connectedness/whānaungatanga, peace/rangimarie, and integrity/ngākau tapatahi (The Caring Community, 2015). As such, the term ‘socially-inclusive’ has been used to describe the group. This refers to the specific practice of welcoming all people to the group, and serves to distinguish it from other groups that maintain certain thresholds for membership. Social-inclusion as an underlying philosophy of the Caring Community motivates the group to also pursue social justice. For all people to be able to be included in a group, time and energy needs to be spent identifying structural barriers to inclusion; not just in the group but in society. Social justice is the active response to knowledge of barriers to social inclusion; “to affirm that men and women are persons and as persons should be free, and yet to do nothing tangible to make this affirmation a reality, is a farce” (Freire & Ramos, 2014, p. 50). Jesus tells a story of clothing the naked, feeding the poor, welcoming the stranger, looking after the sick, and visiting the prisoner, concluding it with the statement “whatever you did for one of the least of these brothers and sisters of mine, you did for me” (Matthew 25:40). In 1984 the Anglican Consultative Council, an international church body, developed five marks of mission. The third and fourth support the

desire of the group to respond to social injustice, “To respond to human need by loving service; to transform unjust structures of society, to challenge violence of every kind and pursue peace and reconciliation” (Anglican Consultative Council, 2017).

The Merriam-Webster dictionary (2017) defines Christian as being “of, or related to, the religion based on the teachings of Jesus Christ”. This definition appropriately describes the Christian faith basis on which the Caring Community was formed.

The Fellowship for Intentional Community (n.d.) defines community as “a group of people who identify with each other. The association could be based on any combination of geography, history, vision, purpose, philosophy, or common social, economic, or political interests”. Adding to this definition they also state that an ‘intentional community’ is a community that “regularly associate with each other on the basis of explicit common values” (n.d.). The term intentional community is not used in this research; however it is a commonly used term by the Caring Community and similar groups they are in contact with. The definition above accurately describes the Caring Community, who gather frequently and have a written document that explicitly states their values and the tikanga that is frequently used.

The Caring Community describes itself as being a ‘safe space’ for participants (The Caring Community, 2014). The term ‘safe space’ dates back to the late twentieth century women’s movement (Rosenfeld & Noterman, 2014) and has come into frequent usage since then, particularly in the social services. Rosenfeld & Noterman (2014) argue that the idea of a safe space should not be viewed from a binary perspective of things being either ‘safe’ or ‘unsafe’ but rather the emphasis placed on the relational work that contributes toward safety. This means paying particular attention to deep differences between people that are often problematic without recognition and negotiation. Within marginalised groups the concept of a ‘safe space’ is one where people can speak and act freely (Rosenfeld & Noterman, 2014). However when people speak and act freely, this can in turn create a space which is not safe for others. Therefore the term ‘safe space’ is really conveying that a space is ‘safe enough’; that there will be times of discomfort, risk, and disagreement, but that there is a commitment to negotiate these times in ways that leave people feeling ‘safe enough’ as stated in the intentions of Colectivo Situaciones (2007, p. 86) “neither to erase nor to disguise differences, but to stop them from setting up certain common problems”.

The methodological choice of narrative inquiry was chosen to complement these values. ‘Narrative’ is a word that means many things in many contexts. In the context of narrative inquiry, and as presented in this research, Polkinghorne’s definition of narrative as “a discourse form in which events and happenings

are configured into a temporal unity by means of a plot” (1995, p. 5) will be used. The world is not experienced by people as individual separate events. People make sense of events by assembling them into groups in order to understand the relationship between them, and this narrative structure is termed the ‘plot’ (Feldman, Bruner, Renderer, & Spitzer, 1990). In this research, the narratives explored are the life stories of community participants, with a focus on the meaning participants give to their stories in light of their participation in the community.

Based on the sample size of seven participants this study is categorised as a ‘small-scale’ study (Denscombe, 2014). It was completed as a component of a Master qualification and was therefore not expected to be as comprehensive as a longitudinal or large sample study. A purpose of the study was to gain insight into participation and belonging within a community group, and to develop a direction for possible further study into this topic. The study is not intended to be used to generalise to a broader population, or to provide sufficient data to initiate a new theory, so the sample size was therefore appropriate for its purpose (Sandelowski, 1993).

As stated above, the question I bring to this study is ‘What are the narratives of adults who are part of a socially-inclusive Christian community group?’ This question is intentionally broad as appropriate to the style of narrative inquiry; it is the stories of the participants that are the focus of the study and there needed to be room to follow these stories in the direction they led. By keeping the question broad it also allowed for any hypotheses I had to be confirmed or challenged, rather than expecting a specific response.

METHODOLOGICAL CHOICE AND STYLE

Narrative inquiry is a relatively new approach (Daiute, 2013) to interpretivist methodology and I chose it as an appropriate methodology based on the underlying stance that we access information to human experience not through direct access to lived experience but through representation and interpretation of it. Nietzsche (as cited in Jameson, 1974) described experience as being in the ‘prison house of language’. Therefore I utilised the innate human skill of transforming lived events into life stories (Judy Atkinson, 2002). This particular group has been chosen for the focus of this proposed piece of research due to my personal interest in it. As a participant in the community group and as a part of the wider geographical community, I am interested in the contribution such groups make to society. I want to gain deeper knowledge of peoples’ journeys into participation in such a group. Narrative research states that stories are a source of knowledge (Birren, Kenyon, Ruth, Schroots, & Svensson, 1996) and therefore listening to participants’ stories can provide that experience-based knowledge.

Personal narratives are rooted in a particular time, place and cultural context (Fitzpatrick & Kazer, 2011) and this is the very reason why they are meaningful and useful. Because I wanted to gain understanding and insight into adults' journeys into participation in the Caring Community, the temporal relativity was helpful to me. I didn't want to hear vague recollections of what may have been, I was interested in hearing specific stories of current experience and to glimpse the meaning in those stories. In this case, the narratives intersect and help to shed light on one another. Together, they make up a rich picture of community experience.

Language is the medium we use to communicate our experience; narratives are constructed via language making, and language is also the tool we use to express ourselves and our identities (Bruner, 1990; Crossley, 2000; Riessman, 2002). The Sapier-Whorf hypothesis is a linguistic relativist concept that states that the structure of language affects its speaker's world-view (Lucy, 1997). Participants' stories gathered through narrative inquiry can be understood as accounts of events experienced in a particular temporality, therefore knowledge is located and constructed in a particular historical context. The advantage of giving consideration to the temporality of human experience is that a deeper level of understanding can be gained from the narratives (Clandinin & Rosiek, 2007). The participant's story is not separated from their world and is understood through the larger context.

It is inevitable that interpretation occurs in a study that relies on human accounts of experience, because narratives themselves are representations. No two accounts of the same instance are ever identical, demonstrating the interpretation that occurs even before we attempt to understand another's account of an event, or add our own interpretation into the mix. As humans, we construct the experiences of our past into personal narratives in order to make meaning and create our identities. The Caring Community, presented through the prism of this research, is not an average of the participants' experiences, but rather the complicated and contradictory sum of the whole.

A Deweyan ontological approach to experience is transactional in nature and it is this very relational approach to being and knowledge that makes my methodological choices appropriate to this Caring Community who hold relationships at the very heart of what they do (Clandinin & Rosiek, 2007). A Narrative approach to interviewing tends to be relatively unstructured, in the case of this research I used the term 'structured conversation' to refer to my conversation with participants. I chose to have a sheet of conversation prompts, but also to allow the participant to direct the flow of the conversation and what topics emphasised. Epistemologically the Deweyan approach that Narrative Inquiry is founded upon

implies that our representations of experience are constructed through our interactions, and that new representations are no more or less true than previous ones, rather that they are currently valid (Dewey, 2007). As stories are told they are shaped by the words selected by the narrator, and then again in the way that they are heard by the listener and it is in this process that the stories in this research were co-created. It is also true that they will then be interpreted by you, the reader. Within the narrative approach there is room for all these levels of interpretation, they are all acknowledged and of value.

The analysis process that I carried out was consistent with a narrative approach to analysis, founded on the belief that individuals' accounts of experience are occurrences that are worth studying in their own right. This is different from other interpretivist approaches that require complex analysis of words within transcripts (Riessman, 1993). I focussed on both the form and the content of the participants' narratives. As part of my analysis process each participant's story was summarised into a core narrative that is contained in Chapter four. Each participant's story is further explored, including voices, motivation and tone as the emerging themes are discussed.

RESEARCH CONTEXT

Having positive, functional relationships and a sense of belonging to something are important to a person's emotional, spiritual, and physical wellbeing (Begen & Turner-Cobb, 2014; Cruwys, Haslam, Dingle, Jetten, et al., 2014; Durie, 2001; Hagerty & Williams, 1999; Jetten, Haslam, Haslam, Dingle, & Jones, 2014). At present, there is a growing demand for social support services (Oakley-Browne, Wells, & Scott, 2006) for people with concerns such as mental illness, addiction, and isolation within New Zealand. People with co-existing disorders find that they are shuffled between service providers, present at subclinical levels, and/or may be disqualified from treatment and access to particular support services (Oakley-Browne et al., 2006). Subsequently, local, socially-inclusive community groups have arisen with the aim of providing needed services to people otherwise discarded. The stories of people involved with these groups are currently under-researched, along with the ways in which participation works to mitigate and buffer the effects of isolation and exclusion (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015).

One such group is a faith-based, socially-inclusive, Caring Community in a rural New Zealand town, located in a low-socioeconomic area with a high prevalence of people presenting with mental illness and/or addiction. The geographical community is noted for its high incidences of family violence, child abuse and poverty (June Atkinson, Salmond, & Crampton, 2014; Hunt, 2015). Statistics New Zealand

data shows the area to have the third lowest average household income and double the national average of beneficiaries. The town has 10% more people who are 65+ years old than the national average, lower than average 20-40 year old population, and 22.8% of the population is Māori (compared with the national Māori population of 14.9%). Only 8.9% of the town's population have an undergraduate degree or higher, 65% of people employed in the town work in labourer, community support worker, healthcare, or sales jobs. (Statistics New Zealand, 2017). Key features of the Caring Community are acceptance, inclusion, and active participation in meals, Bible studies and social support. The Caring Community gathers in a number of places including the local community library, community participants' homes, and primarily the lounge of a local church. There have been periods when there have been shared residential spaces, though these are not currently operating. The local Anglican church, the regional diocese and the Caring Community have covenant of partnership between them, meaning that the wider Church has involvement with the accountability of the Caring Community but that the daily operating of the group is autonomous. The oversight role within the Caring Community is carried out by the 'kaitiaki', a group of people who self-select to be committed to the group, uphold the values, attend Community gatherings including weekly kaitiaki meetings and to hold the kaupapa of the group. Practical decisions are made in monthly meetings of any Caring Community participants who want to attend. Decisions are made after discussion using a concensus decision making process. They state that they aim to bring emotional healing and transformation to people through social connection, participation, and healthy relationships (The Caring Community, 2014). The Caring Community has a particular focus for people who are marginalised, stigmatised, or otherwise excluded from mainstream society. Community group participants range in age from 0 – 85, are both Māori and Pākehā, and represent a range of sexualities and genders. Because of the relaxed nature of belonging to the Caring Community, accurate data breaking down the group is not available. However, kaitiaki estimate that 75% would have a mental illness, 65% would be unemployed or superannuants, 30% would identify as Māori with the rest primarily identifying as New Zealand European. Those who volunteered to be participants in this research project reflect the diversity of the Caring Community well. It was a small sample of seven people and I am thankful to those who participated. Due to the open nature of membership to the Caring Community, it is difficult to exactly state the total size of the group, however the average weekly attendance by adults is around 50. I also acknowledge the work of the Caring Community and the culture of trust that has been created that allowed people of diverse backgrounds to be willing to share their personal stories with me.

The socially-inclusive Christian Caring Community is intentionally committed to biculturalism and attempting to uphold the mana of Te Tiriti o Waitangi (The Caring Community, 2014, 2015). This is also important to me personally and many individuals within the Caring Community; both Māori and Tauwiwi. The Caring Community uses te reo Māori in the written documents they have produced, conversationally where people are able, in signs around common spaces and in waiata. There is also a weekly prayer gathering in te reo Māori. I have attempted to honour this stated value of the community in this research both by respectful inclusion of Māori participants, but also by giving mana to kupu Māori and Māori theoretical frameworks. Respecting te reo Māori as a normal part of New Zealand life, I have chosen not to translate kupu Māori used within the text. Those who require it can consult the glossary in the appendices (See Appendix H).

RELEVANCE AND IMPORTANCE OF STUDY

The purpose of using narrative inquiry is to engage with participants' reflections on their journeys in a way that can bring together various disconnected components into a coherent story that provides insight and deep understanding in an engaging way (du Preez, 2008). Narrative inquiry does not theorise about what may be, or may work, for all people in every context; it is intended that a reader of this research will have a widened perspective and deeper understanding of some people's experiences of participation in a community group, and that this may help them in other similar situations (Polkinghorne, 2010).

The stories of people who have chosen to engage with alternative sources of support, i.e. services that are not directly government funded, are infrequently heard. It is my aim to gain insight into how and why people come to participate in this group and what has kept them engaged. This is of particular interest with regard to participants who otherwise choose not to engage with support services or social groups.

Zora Neale Hurston said "There is no agony like bearing an untold story inside you" (1979, p. 71). This is a study of a small sample, that is not generalisable, but for many marginalised participants in the socially inclusive Christian community group, their story is untold or unheard and there is little provision in today's society for them to tell it and be heard. Therefore the greatest significance of this research will be achieving the documentation of their authentic voices in a way that rarely happens. Beyond that, exploring one way of being community may give insight into a flaxroots and sustainable way to promote health amongst vulnerable people. This study may also open up possibilities for future research into the benefits of socially-inclusive Christian community participation, particularly for vulnerable people as further gaps in knowledge are identified.

RESEARCHER'S BACKGROUND

I grew up in a family that placed value on diversity and empowerment of others. I had great privilege in many aspects of my life growing up. I was Pākehā in a small town that had a higher than the national average Māori and Pasifika population. My parents were still happily married, and were both well-educated with stable jobs. I participated in multiple extra-curricular activities. My sister and I were always close, and we had many supportive people around us. We were not, however sheltered, in the sense that narratives of power and imbalance of power, feminism, anti-racism, structural abuse, equity, and social responsibility were strong and ever-present around our abundant dinner table. I have early memories of parents' friends seeking refuge in our house from abusive husbands, violent family members and money struggles. My parents had money, but it seemed sometimes that the sole purpose for this was for it to be given away. Experiencing, and understanding, other cultures was encouraged. Challenging the status quo was the status quo in our house and it was expected that what privilege and power we had we would use for the empowerment of others.

These early encounters with a wide range of people from all walks of life, and the unconditional love I saw my parents express for all people are indelible in my mind and being. I was committed to the idea of helping others and of the value of genuine expression of spirituality. Now as a married professional woman with three children, I am working out how to embody perspectives that have previously been largely theoretical. This research is a bringing together of those aspects of myself: counsellor and Christian. It is an exploration of community and identity, how people belong and what they make of belonging.

For some researchers, narrative inquiry is a way of representing data, for me it is an ontological commitment to the understanding that experience is relational and constructed narratively. As Riessman said "We cannot give voice, but we do hear voices that we record and interpret" (1993, p. 8)

In both the context of counselling and in narrative inquiry I am asked whether people lie in the stories they tell me, and whether this matters. The Personal Narratives Group (Barbre & Group, 1989) referred to the inevitability that people lie, forget details, make mistakes and exaggerate aspects of their stories and yet say that at the same time people reveal truth through the way they represent their experiences. It has been important to me throughout this process (as a daughter of scientist) to consciously maintain my commitment to people's stories and their meaning, not to the pursuit of objective 'hard data'.

In my professional background as a counsellor and mental health professional I have met many people who lack the social support to help them enact change, or even simply to maintain a functioning level of health. Sometimes individual-focussed therapy can even contribute to this, by perpetuating the isolation of an individual and not helping them to extend their support systems in their everyday life (Brown & Smart, 1991; Kensit, 2000; Sherman & Cohen, 2006). Oftentimes counselling can be a useful tool for people like this to access, however it is not a lifestyle, and is often an inadequate solution long term. I maintain that humans are social creatures, that we are not meant to live out our existence in isolation and that it is therefore important that we have community, in one shape or another, to be a part of.

My own participation in this particular Caring Community has been both challenging and rewarding. Through it I have seen strength in myself and also weakness. It has been a place where I have explored who I am, and what I am, in more depth than ever before. I frequently have the things I claim to believe challenged, and yet to experience the love and friendship of such a wide range of fellow humans, who have chosen to have me in their lives is a profound experience. Being a participant of the same Caring Community that I am researching had its challenges for me. Oftentimes I found myself knowing about a situation that a participant was referring to, however they were not describing the situation, only mentioning their response to it, for example. I had to make choices about when to ask for more information, or not, knowing that as researcher I was in a position of power and not wanting to push people into a situation where they felt required to disclose more than they wanted to. On the other hand, I was also aware of the feeling of awkwardness that can come when telling someone a story that you are both aware they already knew; perhaps the participant was just trying to avoid this awkwardness? I think I tended to err on the side of sensitivity, resulting in moments where opportunities for richer data were lost. Another struggle I faced was in defining the community; for the sake of the reader I needed to be explicit that the group was founded on the principles and values of Christianity. The difficulty in this was that although all participants of the Caring Community are aware of this, they may not personally hold a Christian faith themselves, and may express spirituality in ways that are not considered Christian. Within the Caring Community this is commonplace and accepted and valued; the deity prayed to by many is not always Jesus. For these participants I felt that it misrepresented them, or diminished their views to be so concrete in my description of the group. I recognise that this struggle is also a representation of my own difficulties locating my faith in Jesus within institutions that act in ways I cannot fathom and see this as an example of writing in words what is ultimately a relational experience.

INTRODUCTION TO THIS COMMUNITY AND ITS CONTEXT

As an insider researcher (Kanuha, 2000), I shared substantial group and assumed knowledge with the participants. I explained to them that I would only include information about their lives that they shared during the structured conversations (see Chapter three). However, I did not require they spell out common group knowledge, such as group terminology, agreed values, kawa etc. As an aid to understanding the research, and the allusions made to group knowledge in the participants' stories, I include here a summary of the genesis, aims and values of the Caring Community.

This socially-inclusive Christian Caring Community aims to be an inclusive and non-judgemental place where people can come together for mutual support and encouragement. The community places a particular emphasis on being a safe place for people who experience marginalisation.

Similar to other emerging caring communities (Marti & Ganiel, 2014), the community both emerges from, and is a reaction to more mainstream forms of contemporary Christian church. In common with mainstream churches, the community places emphasis on love, support, spirituality and reliance on God. In reaction to traditional religion, the community aims to be a place where people who often experience marginalisation or judgement in churches can be safe and welcome. I recall in the early days of the Caring Community, having conversation amongst the kaitiaki of wanting the Caring Community "to be Church for people who can't stand Church." The community also avoids imposing beliefs onto people, rather encouraging them to form their own opinions, and to erase distinctions between leader and follower, or helper and helped, believing all people have valuable contributions to share, and times when they need support. The emergence of these kinds of caring communities is also a response to the need for a physical space for excluded people to form relationships; a structural response to this need is often the establishment of drop-in centres, however caring communities aim to have a more egalitarian and relational approach to addressing this need (B. Kerr, personal communication, July 10, 2017).

One kaitiaki of the Caring Community shared how they had been inspired by the words of the then Wellington City Missioner, Susan Blakie (personal communication 2010, original source unknown), "God requires faithfulness, not success". This gave the kaitiaki a sense of safety within which they could give things a go, test out new ideas, all the while with their focus on being faithful to God and their perceived calling, rather than the concept of success or failure.

Despite popular culture, and even some spheres of academia (Carr, 2000), often using the terms 'spirituality' and 'religion' interchangeably, the distinction is very important for people who have been excluded by religious institutions or struggles with some of the practices of organised religion. Carr (2000) defines religion as the structures beliefs and traditions of an organised denomination or faith. Spirituality, on the other hand focuses on a belief in something bigger than yourself, "a larger spiritual force" (Corrigan, McCorkle, Schell, & Kidder, 2003, p. 488) that may include the practices of traditions of religion to support that belief (Croucher, Sommier, Kuchma, & MeInychenko, 2015). In her article entitled 'Conformity or growth' Johnson (2004) described her struggles integrating her perspectives as a woman in church ministry and as a counsellor. In particular she struggled with the church's treatment of gay people, and what she felt was a tendency for the church to be controlling and imposing of beliefs and behaviour. The Caring Community which is the focus of this study was born out of similar struggles. The original kaitiaki also struggled with the hierarchical approach of the traditional church which tended to suppress minorities and expression of difference. Neither Johnson, nor the kaitiaki desired to abandon their spirituality in the form of Christian faith, and they all sought to find a way to express that in an alternative way.

The Caring Community from this research has chosen to interpret the Bible in such a way that mandates the group to operate from a values-base rather than rules-base. Their decision to operate the group from a values-base is born out of recognition that life is messy, and lived in the grey spaces. The Caring Community has discovered that people tend to want to find loop-holes if they are confronted by rules, but that a set of values can be used as a net to filter any decision through. Tikanga Māori is also based not in rules and regulations, but on values as a measure of appropriateness and adequacy (Durie, 1994; Mead & Mead, 2003).

The emphasis on the power of narratives, and the ability for people to mould and shape their own narratives, also underpins the ethos of the specific caring-community I researched. I understand that this can be attributed, in part at least, to the majority of the founding kaitiaki having a background in social-services and specifically counselling. It was important to me not to attempt to research the community in a way that would be inconsistent with their stated values.

One of the concerns critics often raise about narrative methodologies is the validity of personal stories as 'data' (Frank, 2000). Many positivist thinkers consider stories to fit in a binary system of either being true or false. In contrast however, feminist post-structuralist Davies describes them as the 'means by which

events are interpreted, made tellable, or even liveable.’ (1991, p. 43). Riessman (1993) describes a number of interpretivist views of truth and narrative; some say language represents reality (Labov & Waletzky, 1967), others that narrative creates reality (J. L. Young & Griffith, 1995), others that narratives are realities with infused values or biases (Langellier, 1989), and others still maintain that narratives are fictions that the speaker wants to be reality (Veroff, Sutherland, Chadiha, & Ortega, 1993). All human beings are confined within a particular historical period so the truths we construct are always constrained by context. Any story we tell is narrated through the lens of our time, our position of power or powerlessness, and our culture. As we broaden the perspective within which we listen, in order to take into account culture, social structure, individual experience, power, and powerlessness it becomes less about reality and more about a point of view. As I wanted to know more about individual’s experiences this was an appropriate approach that was respectful of the participants and their autonomy over their story.

CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

This literature review explores the current literature in relation to socially-inclusive Christian caring communities, with an emphasis on belonging and participation. The review draws upon selected and relevant writing from across disciplines, theoretical perspectives and practices. This review begins with a consideration of the role of narratives; not only in research but in our relationships and understanding of the world around us. Thereafter topics relevant to the Caring Community are explored, and then literature connected to the participants' experiences. Particular emphasis has been placed on research that contained perspectives of te ao Māori positioning them within a uniquely New Zealand/Aotearoa context. Christian perspectives have also been explored due to the Christian foundation of the Caring Community.

The databases included in the literature search were: JSTOR, EBSCO, PsychINFO (via OVID), OVID Databases, SAGE Research Methods, Wiley online Library, ScienceDirect and NZAC Journal archives. A search strategy was used which included key search terms and related word, for example: 'socially-inclusive', 'Christian', 'small group participation', 'Christian group belonging', 'safety in mental health groups', 'mental health OR addictions' 'Aotearoa OR New Zealand', 'Māori mental health', 'Māori spirituality'.

Priority was placed on the inclusion of articles from 2007 onwards, however articles and books that pre-dated 2007 that are considered authorities on particular topics were included, as were articles that included information on topics on which there was limited research available. Articles also needed to be from English and te reo Māori publications. The initial literature review was carried out in 2016, with additional searching utilised during 2017. This literature review was an important aspect of the research as it enabled the study to be situated within existing knowledge, whilst critically reflecting on that knowledge and any gaps in the literature.

ROLES OF NARRATIVE

How individuals recount their histories – what they emphasize and omit, their stance as protagonists or victims, the relationship the story establishes between the teller and audience – all shape what individuals can claim of their own lives. Personal stories are not merely a way of

telling someone (or oneself) about one's life; they are the means by which identities may be fashioned. (Rosenwald & Ochberg, 1992, p. 1)

Narrative therapy has been used in post-apartheid South Africa as a way of deconstructing faith in congregations and facilitating a shift toward missional church life (Smit, 2015). A narrative approach to pastoral theology has allowed churchgoers a method for deconstructing their stories in light of a differing understanding of God and society. It also then provided a way to reconstruct their stories consistently with their understandings (Smit, 2015). Whilst narratives hold a significant role within varied professional disciplines and as such are well documented in these fields, there is less research existing around how people tell their stories within their everyday lives, and how they tell their life stories whilst not as a part of therapy or with a specific goal.

NARRATIVE AND BEING HUMAN

Sarbin described 'narrative principle' as being the principle by which 'human beings think, perceive, imagine, and make moral choices according to narrative structure (1986, p. 8). According to Sarbin our thoughts and actions are guided by narrative structures, along the lines of narrative plots. Bruner (1990) emphasised the impact that culture has on our own innate individual drive toward narrative structure, referring to the cultural overlay we are each born into as a 'tool kit' through which we tell and interpret our stories.

NARRATIVE AND MEANING MAKING

As humans we are always trying to make sense of the chaos of life around us, trying to find order in the disorder and being driven by a need to 'interpret' or explain 'what is happening in and around us' (Crossley, 2000, p. 10). For individuals and groups, language is the tool by which sequence, meaning, and connection are moulded from seemingly disconnected events and experiences (Crossley, 2000). This is done in order to also mould meaning and order in our lives. A product of the interaction between people is meaning; a contextual and fluctuating construct.

NARRATIVE AND IDENTITY

Bruner (2003) wrote "'Self' is a surprisingly quirky idea - intuitively obvious to common sense yet notoriously evasive to definition by the fastidious philosopher (p. 63)." Underpinning narrative approaches to research is the idea that people construct their identity via narratives. According to Engel (1995) it is through telling stories to others that 'we construct ourselves' (p. 185). A narrative view of

identity involves taking the objective, largely 'inner' view of self and stretching it to include subjective interaction, a view of self that takes into account the social, cultural and historical context of the individual and its impact on formation of 'self'.

Pūrākau are a traditional form of Māori narrative containing philosophical thought, epistemological constructs, cultural codes and world views (Lee, 2009). Customarily, Māori considered pūrākau fundamental to understanding the world (Hikuroa, 2016) and to view them simply as stories, or fiction, is an overly simplistic interpretation of the significance of pūrākau as a method of teaching, learning, and transferring mātauranga multi-generationally (Lee, 2008). More recently pūrākau has been further developed as a decolonising methodological approach to kaupapa Māori research; a culturally responsive adaptation of narrative inquiry. "Storytelling has always been one of the key ways knowledge was sustained and protected within indigenous communities. Reclaiming storytelling and retelling our traditional stories is to engage in one form of decolonisation (Lee, 2009, p. 93)." Pūrākau is a kaupapa Māori form of storytelling which has been increasingly documented, there is little research, however, into storytelling within a bicultural context. For instance, there could be a way that acknowledges both Pākehā and Māori methods of storytelling, and draws from them both allowing all people to tell their stories in a space that is culturally safe for all.

CHRISTIAN FAITH-BASED GROUPS

In her presentation 'Transforming Communities: faith based social justice group work with homeless', Fisher (2012) reported finding few published studies on social justice group work carried out by faith-based groups. As there are many faith-based social justice groups, this gap in the literature suggests research needs to be done in this area. Such groups should be inclusive and participatory, believing in the ability of people to unify in order to effect change. In order for this to happen, group leaders need to help create a group culture within the group whereby participants feel affirmed and valued as part of proceedings and decision-making (Fisher, 2012). When participants in the faith-based social justice group that Fisher (2012) researched responded to questions about the value of the group, the overwhelming theme was a recognition of the significance of human relationships over programmes.

Studies have shown faith related spaces in which small groups contribute to change. Despite their official theological positioning, in reality churches are often relatively segregated ethnically, culturally, and economically (Christian, 2012). When Christian (2012) researched the role of church groups as agents of reconciliation and change he found that the effective use of small groups made a positive difference.

Schwarz's (1999) research into natural church growth concluded that 'holistic small groups' are the factor most significantly associated with both numerical growth and the emotional health of a church. The growth of a small group itself is connected to four factors: the prayer life of the leader, a focus on people beyond the group, caring relationships, and empowering leadership (Jim & Wei, 2014). Particularly important were the factors of remaining outwardly focussed and empowering participants in leadership. Conversely to what people may expect, there appeared to be no correlation at all between the time spent preparing for group session by a leader and the numerical growth of the group (Jim & Wei, 2014).

There appear to be many benefits for those who participate in faith-based small groups. These include the following: Church small group participants experience a stronger connection with church; small groups enhance ethnic diversity in the whole church; numerical growth of churches due to small groups; and a positive effect on participants' outlook (Walton, 2011). Most of the studies included in Walton's writing focussed on small groups that were from 'large' congregations, so whether these effects are also present for participants of small groups from small congregations, or small groups that are entire congregations is unknown. One reason Walton found that people have increased engagement via small group participation is that the groups provide the participants with opportunities of faith engagement that are not normally available during a church service where a congregant decides internally whether or not to accept what they have heard. Robert Wuthnow (1994) conducted a three year long research programme in which he interviewed nearly 2000 people and carried out intensive case studies on 12 small groups. Wuthnow (1994) found that 71% of participants felt more able to forgive others as a result of their small group participation, 69% reported being able to better serve others, and 84% say they felt better about themselves because of their participation (as cited in Walton, 2011)

Despite the apparent positives inherent in faith-based small groups, without careful attention to factors that facilitate the benefits, groups may not achieve them. One of the dangers of small group participation is that it merely contains individuals, providing them with the opportunity to "focus on themselves in the presence of others" (Wuthnow, 1994, p. 6). Walton (2011) noticed that many Christian small groups will default to a model of largely moral support. This facilitates a sense of belonging and mutuality, but without learning, challenge, or accountability social change is not achieved. Faith-based community organising (FBCO) is a step beyond faith-based community groups. The focus shifts from mutual support to activism within the community and it has been posited as a valuable way to facilitate individual and group empowerment (Christens, Jones, & Speer, 2008). Research silos tend to keep faith separate from community organisation and vice versa (Christens et al., 2008) and FBCO attempts to combine the

strengths of both. Many participants within the Christens et al. (2008) study mentioned that idea of community organising, or activism, was an essential element of their ‘spiritual calling’.

The way that a faith-based group forms or operates is changing as ‘spirituality’ becomes a topic more openly talked about in current culture, and religion less so, heralding an understanding the one can be spiritual without being religious. An interesting result of this social change is that many people want to ‘follow Jesus’ and eschew organised religion (Smit, 2015). As individuals within the Christian church engage with the post-modern shift in thinking, a deconstruction of their faith and religion occurs. In this context, new approaches to theology are being developed in order to reconstruct people’s faith, most often from a missional approach (Smit, 2015). Jamieson had similar findings in his New Zealand-based doctoral thesis ‘A Churchless Faith’ (1998); people were leaving churches and ‘disaffiliating’ from particular denominations but were maintaining a personal faith and faith practices, often alongside others with similar experiences. Authors Cloud and Townsend report the benefits of small groups as helping people to heal, grow and mature and also to normalise difficulties in life through discussion within the group (2010). The authors also posited some theoretical benefits from small group participation including an awareness of the source of strength that social connection can provide, feeling less overwhelmed by circumstances, an increase in self-awareness and a decrease in self-judgement (Cloud & Townsend, 2010). There is a paucity of research that includes academic discussion combining both theological and psychological thought on small-groups and the benefits experienced by participants. There is also a lack of research that explores more than one of the various aspects Christian groups concurrently. The themes explored in literature include faith, spirituality, Christianity, community organising, and small groups, however these are not looked at together despite the interconnected nature of these aspects of people’s lives. Research that looks into the experiences of Christian small groups with a focus on social justice tend to split into research on ‘helpers perspectives’ and separate research on ‘help recipients perspectives’. This leads to research that focuses on one aspect of diversity rather than exploring community life from multiple perspectives.

WAIRUATANGA

“Ko te Atua te matapuna o nga mea katoa” (God is the source of all things)

When considering spirituality and faith in the unique context of Aotearoa, special attention needs to be paid to wairuatanga. Western culture is developing a more holistic language to describe spirituality, as demonstrated in this definition from an American study “‘spirituality’ is the psychological sense and/or

experience of being a part of or connected to a realm of existence beyond one's immediate self or situation" (Christens et al., 2008, p. 5). However wairuatanga refers to a spirituality that is interwoven into all aspects of life, known by and through experience (McLennan, 2010). It connects a person to all people, past and present, and the 'universal mystery'. The connection is intuitive and creative, designed to establish an individual in the context of the whole. "It becomes evident through the expression of awe, wonder, trust, faith, hope, love, and peace (McLennan, 2010, p. 2)." Within wairuatanga the physical realm and the spiritual realm are connected, not by a single path, but always, everywhere, and in all directions. All people are connected back to Atua via our genealogies, and those links are considered tapu. Underlying all wairuatanga is the concept of tapu. "Tapu has many meanings: being, dignity, sacredness, restrictions (Tate, 2002, p. 39)." The interchange between people and tapu is navigated by the values of communal responsibility, accountability and connection (McLennan, 2010).

Atua is the source of wairuatanga and the focus of it, and as such, people are the creations of the love and mana of Atua. This establishes the connection between us and Atua, "from God's being-in-relationship, there flows forth in love, a spiritual power (mana) which creates all non-divine reality, and sets it up in relationship to God's being (Tate, 2002, p. 40)." This connection extends beyond humans to other creatures and the land; each connection provides sacredness and dignity, and becomes a part of each person, meaning that when interacting with each other these connections cannot be ignored (Tate, 2002).

These relationships and connections bring people out of the temporal world and into relationship with the universe in the transcendental world (Marsden, M. as cited in M. King, 1977). This is referred to as a state of 'mauri oho' or spiritual awakeness. It is a space of knowledge and uncertainty, a transitional space. "The image of peoples' hearts establishing channels of contact, connection and communication with kaupapa, environments and others is central to comprehending this construction of mauri oho" (Pohatu, 2011, p. 6). As the state of mauri oho increases we become more secure and respectful in our relationships. Kerr (2015) describes this transition as "an awkward stage with multiple opportunities for getting it wrong" (p. 380) due to residing in the in-between spaces where there is need for "love and relationship, courage and humility" (p. 404). This is seen in the Caring Community as people's relationships with one another ebb and flow, but the proximity requires a humility and recognition of connection with one another to maintain the environment. The insight gained from exploring the concept of 'wairuatanga' as distinct from simply a translation of 'spirituality' is useful, however more research is needed that looks into the expression of wairuatanga by non-Māori, and within a bicultural context.

SOCIAL JUSTICE – A CHRISTIAN PERSPECTIVE

Christians are called to faith and works that lead to a restoration of right relationships. Whether an individual's relationship with a neighbour, the relationship of one tribe to another, or one nation to another. Fairness simply does not satisfy the demands of justice. (Poe, 2007, p. 466)

Social justice is a fundamental tenet of Christian faith, and also of social service provision (Poe, 2007), a necessary focus to achieve social-inclusion. The Salvation Army defines social justice as “when a society enables all its members to participate in, and have access to the social, cultural, political and economic resources that define a normative way of life for that society (The Salvation Army, 2005).” Poe describes social justice as more than the elementary concept of fairness, that it also encompasses the human desire for wholeness and unity in relationships. People can have an equal share of food, for example, but justice has not been achieved if the relationships between those people are still fractured, if the table remains in frosty silence. Justice is a concept that is located in cultural and historical context. There are commonalities that can be found however, especially as Christians continue to draw their understanding of social justice from the Bible. Narratives of justice run strongly through both the First and Second Testaments of the Bible. The Bible refers to the Christian God as a ‘just God’ (Deuteronomy 32:4) and states the answer to the question what God requires of humans as, “to act justly, love mercy, and walk humbly with your God (Micah 6:8).” A Biblical sense of justice is more than the equitable distribution of resources; its very basis is unity of relationships. Cassidy (1989) describes justice as “putting love into structures (p. 442).” Perhaps then justice can be found in the balance of love and fair structure. According to the Caring Community the Biblical worldview of justice is to restore relational unity through values and relationships and cannot be dictated by rules.

A bicultural approach to research in New Zealand and to the Caring Community, is a response to the worth of justice for all people. Dr Martin Luther King Jr. said “injustice anywhere is a threat to justice everywhere (1964, p. 77).” The response of a community to injustice is therefore a measure of its own internal justice and wholeness. When Waldergrave and the Family Centre were establishing ‘Just Therapy’ it was in response to the knowledge that helping people to become content in poverty meant they were unintentionally becoming implicit in structural injustice (Waldegrave & Tamasese, 1994). They became aware that ‘liberation’, ‘sacredness’, and ‘belonging’ were needed for health, and that in this uniquely New Zealand context, this meant especially liberation for Māori. The Catholic Church’s long history of social education on the ‘common good’ is summarised by Poe (2007) in three premises; that all

people are created in the image of God and as such are valuable, that God created us as social beings who need to live in community, and that each person has a right and associated responsibility, to share in the natural resources. The prophets of the First Testament were also very vocal on the topic appealing for the people to “establish justice (Amos 5:15)” and “to preserve justice (Isaiah 56:1)” and defining a just person and their actions (Ezekiel 18:5-9).

Many counsellors’ client work is largely based around the client learning new coping strategies to manage stressors effectively (Crethar, Rivera, & Sara, 2008). There is a growing number of counsellors who work from multicultural, feminist and/or social justice paradigms and as well as teaching coping strategies, these counsellors work to acknowledge and intentionally alleviate the social and structural injustices that people face (Crethar et al., 2008). On this basis some studies are encouraging helping professionals to expand their skillset from individual interventions to include community and organisational approaches (Fisher, 2012; Singh & Salazar, 2010). This approach to counselling requires professionals to have an understanding, and possess accurate information, about the various forms of discrimination, marginalisation, and injustice that face the people they encounter. Neglecting to acknowledge the reality of the external factors that a person faces can be damaging (Booth, 2008; Waldegrave, 2005), and therefore a social justice approach to the helping professions is essential.

What social justice looks like when the principle is taken beyond the distinction between ‘helpers’ and ‘recipients of help’ is not explored fully in current literature. The concrete change in people, or groups of people, that occurs when they take on the concepts of social justice is not described. Research that looks at the lived experience of people who have shifted their thinking to a paradigm focussed around social justice would help to make clear what exactly ‘social justice in action’ looks like.

TRANSFORMATIONAL LEARNING

Transformation learning theory is based on the premise that deep change is possible for adults via a process of learning and that it is possible to understand that process (C. J. Young, 2013). It is not a theory that is focussed on the teacher, but on the learners, describing the ways that adults interact with their experiences in a way that effects change. This is a partial response to the above mentioned gap in academic knowledge of what social justice looks like.

We see accounts in the Bible of Jesus engaging with adults and facilitating self-reflection in people that promotes significant change (John 4:4-26, Luke 19:1-10). As readers of the Bible/followers of Jesus, we

read these stories with interest in the dynamics of those conversations and the moments of choice or change experienced by those around him.

Sometimes transformation occurs in a person's life following on from a significant event or trauma that challenges the core beliefs and understanding of reality the person holds (Wagner, 2007) and this is often referred to as post-traumatic growth. Whilst this can be a positively life changing scenario, as helping professionals it isn't a complete enough picture of transformation, we have to believe that people can change without first experiencing trauma. This is where the role of a group can come in. Although transformational learning theory is focussed around an individual it operates from the perspective that humans are social beings (C. J. Young, 2013). Taylor's study, conducted in 2000 (as cited in C. J. Young, 2013) reports that 'rational discourse' is the primary method through which transformation occurs. This theory articulates the culture the Caring Community needs to be creating to facilitate transformational learning, "trust, friendship, [and] support seem to provide the conditions essential for effective rational discourse (p. 306)." Freire (2014) also described the need for trusting relationships within which learning can happen; "any situation in which some individual prevents others from engaging in the process of inquiry is one of violence... to alienate humans from their own decision making is to change them into objects" (p. 85). The Caring Community of this research claims to be transformational through community and relationships (The Caring Community, 2014). Perhaps this may be due to its provision of a space where individuals maintain their own integrity while moving toward connection, and sustaining discourse within a group.

Young (2013) reports that there is growing acknowledgement, within some sectors, of the spiritual nature of transformational learning as a process. There has been considerable attention paid to deep learning in the Christian global community with particular reference to moments of 'conversion' (Kegan, 2009; Loder, 1981). Loder (1981) describes transformational learning as 'intrinsically spiritual' because the focus is beyond simple survival. Transformational learning theory focuses on how we flourish as people; people who are created in God's image.

As society has become increasingly secularised, the spheres of Christian knowledge and educational knowledge have been pushed apart, rooted in Descartes (C17th) principle of "I think therefore I am". This Caring Community is attempting in their small part of the world to reintegrate these, through professional knowledge and skills, religious experience and knowledge, and spiritual experience and knowledge. Transformational learning as a theory describes the process the Caring Community is trying to facilitate

in order to see personal and community transformation. Young (2013) is bold enough to claim that transformational learning is the process Christians hope to foster in others saying, “this is the process that the Holy Spirit uses in people’s lives. This is how the Holy Spirit causes people to learn (p. 337).” Due to the learner-centred approach of transformational learning it is not clear whether or not it can accurately claim that the Holy Spirit ‘causes’ people to learn. We can however, work on the basis that humans have the role of creating the culture that facilitates the work of the Holy Spirit. The impact of individual transformational learning on the wider community cohesion and ongoing relationships is not spelt out in the current literature.

A similar Māori concept of transformational learning called ‘Te Wā’ exists. It focuses on the learning within the dynamic relationships with others. “Te Wā is a moment in the lives of people, marking stages in their journey of life when their tapu was addressed, enhanced and restored, or [when] they addressed , enhanced, and restored the tapu of others (Tate, 2002, p. 51).”

SOCIAL IDENTITY

Part of developing a sense of belonging within a particular group is the exploration, and defining of individual and social identity (Postmes & Jetten, 2006). Narrative psychology puts an emphasis on the link between ‘self’ and ‘social structures’ (Crossley, 2000). Potter and Wetherell articulate the connection as follows; “the question becomes... how is the self talked about, how is it theorised in discourse?” (1987, p. 102). One of the most powerful human desires is to create and sustain social relationships (Baumeister & Leary, 1995) and people develop and grow through their relationships with others (Hagerty, Williams, Coyne, & Early, 1996). Groups, and our interactions within them, play a central role in an individual’s identity creation as personal and social identity are interdependent (Postmes & Jetten, 2006). One aspect of engagement with a group, is an individual balancing the desire to belong and the desire to individuate from others in the group, resulting in a person’s social identity (Baumeister & Leary, 1995; Postmes & Jetten, 2006; Tajfel, 2010). Davies and Harre (1990) venture that individual identity is predominantly a result of ‘discursive positioning’, how we are defined or positioned in dialogue with others. This suggests that our social identity is fluid and changing as conversation between people continues. This view of identity, as formed through the interchange of individuality and social engagement leads away from the idea of personality being a construct of fixed traits. Social identity is “an ongoing social and practical accomplishment that is formed, managed and altered through interaction

with others” (Holman, Gold, & Thorpe, 2003, p. 61), identity is not pre-determined and it is always open to reinterpretation and misinterpretation.

Our social identities play a role in the state of our well-being and mental health (Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014; Haslam, Jetten, Postmes, & Haslam, 2009; Jetten, Haslam, & Alexander, 2012). This role can be a hindrance or strength. Persistent threats to social identity can activate biological changes that can create a vulnerability in individuals to stress-related impairments, both physical and psychological (Jetten et al., 2012). Conversely, building collective resilience through social identity can contribute to an increased ability to survive and thrive following disaster or trauma (Jetten et al., 2012).

Māori attributes of identity locate an individual within a social unit (Mead & Mead, 2003). The Māori word for identity is tuakiri: “Tua means to be on the farther side of something, and kiri is skin. Tuakiri probably refers to the elements away from the body that help define the identity and personality of a person” (Mead & Mead, 2003, p. 273). Tuakiritanga looks inwards toward the sites where identity is formed, and outward to where the inner person is received from the outer places (Pohatu, 2011). Tuakiritanga also draws on the *hoa haere* (constant companions) of *whakaaro* (thought), *te rongo* (intuitive knowledge), *te mahara* (reflection), *te whiriwhiri* (discussion and interaction) *te kōrerorero* (valued talk), and *te wetewete* (analysis). These are then applied to the different sites of identity formation to further the multiple interpretations of identity within relationship (Pohatu, 2011).

‘Bonding social capital’ refers to communities that are introspective and comprised of similar people. Other communities, referred to as having ‘bridging social capital’, encompass a variety of people and tend to be outward looking (Block, 2009). A well-functioning representative community requires bridging and bonding social capital: “[A] society that has only bonding social capital will... [Be] segregated into mutually hostile camps (Putnam, Feldstein, & Cohen, 2004, p. 2)”

PARTICIPATION

Health and social sciences hold the belief that participation contributes to health and wellbeing (Campbell & Jovchelovitch, 2000; Jetten et al., 2012; Piškur et al., 2014). The World Health Organisation defines participation as involvement in a life situation (World Health Organization, 2001). Regular participation in meaningful activities and relationships with others helps people to feel ‘whole and equal’ (Granerud & Severinsson, 2006) and regular participation in a social situation, i.e. club, church, or work, leads to a sense of belonging and in turn leads to a positive outlook and faster recovery from mental health issues

(Granerud & Severinsson, 2006). Although a simplistic concept, the impact of merely participating in groups is significant, “As a rough rule of thumb, if you belong to no groups but decide to join one, you cut your risk of dying over the next year in half” (Putnam, 2001, p. 331).

BELONGING

The sense of belonging is a fundamental experience for us as social beings and is particularly important to our well-being. (Putnam, 2001). Defined here as involvement in a group in a way that participants feel a valuable and important part of it (Anant, 1967), belonging is considered as a crucial part of a person’s psychological and social functioning (Hagerty et al., 1996). It is preceded in Maslow’s (Maslow, 1954) hierarchy of needs by only physiological requirements and safety. A sense of belonging positively affects people’s resilience, health and general well-being (Jetten et al., 2014), and is seen as one way of invoking social cure to trauma, stress, and mental illness (Jetten et al., 2012). In saying that, some people feel disconnected and isolated from their social and cultural groups. This is especially true of people who have experienced multiple forms of oppression (Reynolds & Pope, 1991) with people who have experienced marginalisation expressing an increased need to belong to social groups as a result of the exclusion they have experienced demonstrating the significance of a sense of community belonging for a person’s psychosocial wellbeing (Harris, Battle, Pastrana, & Daniels, 2015).

Primarily, a sense of belonging is a subjective sensation; a perception based on feelings of respect and acceptance. Mahar, Cobigo & Stuart (2013) define a sense of belonging as “a subjective feeling of value and respect derived from a reciprocal relationship to an external referent that is built on a foundation of shared experiences, beliefs or personal characteristics” (p. 1026). A common sense of socially constructed meaning provides people with feelings of security and acceptance from within the group (Sedgwick & Yonge, 2008) leading to a perception of being welcomed, respected, and validated (Goodenow & Grady, 1993). These perceptions and feelings vary in response to how connected a person feels to the group and how much their personal values match up with those of the group (Levett-Jones, Lathlean, Higgins, & McMillan, 2009).

A sense of belonging requires that there is something to belong to (Mahar et al., 2013). The group boundaries become defined through processes of inclusion and exclusion (Caxaj & Berman, 2010) and these processes can mean that an individual can be identified formally as a member of a particular group without feeling a subjective sense of belonging. Therefore, it is important to look at people’s perception as separate from their formal objective status of belonging.

Reciprocity reflects a connectedness between people. Shared experiences, values, knowledge and understanding create reciprocity that contributes to a sense of belonging. This reciprocity is deeper than simply shared physical or behavioural characteristics (Mahar et al., 2013) with studies showing it is the shared experience and values that create a sense of comfort and safety for people (Bettez, 2010; Levett-Jones et al., 2009).

A sense of belonging is a dynamic perception, with elements of both the physical and social contexts strengthening and diminishing it. The differing elements that can enable and obstruct belonging, and the dynamic interplay between these factors are relevant when considering belonging. Physical enablers or obstructions may be things like geographic location, physical access, cost or safety. Income, for example, has been found to be related to belonging, with lower-income people recording a lower sense of belonging, and greater isolation than people with higher incomes; with Stewart et al. (2009) finding that many low income earners reported engaging in self-isolating behaviours due to a perceived stigmatisation around being unable to participate in financially costly social activities. Social enablers or obstructions may include discrimination, political climate or group behaviours. Single people and people with a long-term health impairment, students, and unemployed people report significantly lower senses of community belonging (Stewart et al., 2009). Friendliness and helpfulness have been found to be the most important traits in creating a social space in which people can experience belonging, conversely an absence of these attributes resulted in people experiencing feelings of isolation (Stewart et al., 2009). Other attributes identified that contributed to belonging were tolerance, reciprocity, honesty, trust, friendliness, helpfulness, and considerateness.

The idea that a sense of belonging contributes to positive health outcomes for an individual is well documented (Greenfield & Marks, 2010; Hagerty & Williams, 1999; K. D. Hudson, 2015), meaning that a sense of belonging may be important to wellbeing not only on the individual level but also at a community level (K. D. Hudson, 2015). The health impacts of belonging have been specifically noted for people with mental health problems; the World Health Organisation (WHO) emphasises the importance of actively promoting social integration among and expanding the social networks for them (Jané-Llopis, 2006). People have reported significantly higher life satisfaction when they have strong social connections and support that they frequently utilise (Jetten et al., 2012).

One final aspect that contributes to an individual's sense of belonging is their ability to choose to belong or not. Self-determination respects the right of an individual to make their own choice about what they

belong to (Mahar et al., 2013), making it important to consider whether people feel they *can* or *want* to belong when exploring the sense of belonging participants feel with a particular group. Genuine belonging requires a person to have autonomy, tino rangatiratanga in their choice to belong. There is a wealth of research generally about the processes by which people develop a sense of belonging, social identity, and personal identity. Whether these processes have been specifically assessed as valid and consistent for people who are marginalised and previously experienced a lack of belonging and social inclusion is unclear. It is possible that these previous experiences impact and alter the way that marginalised people engage with groups and this needs to be researched specifically.

SOCIAL INCLUSION

Social inclusion refers to people having equal opportunity to engage socially and create connections. A New Zealand government policy document describes social inclusion as focussing on “the relationships between individuals and groups, and their belonging, participating in and contributing on their own terms to our common life in families, communities and society as a whole” (Bromell & Hyland, 2007, p. 10). Social inclusion provides meaning, belonging, self-worth, stability and a sense of responsibility for others and therefore self-care (Jetten et al., 2012). It also provides sources of emotional, financial, and practical support. One Swedish study found that the correlation between stressful life events and risk of mortality was reduced among participants that believed that they had sources of emotional support, a product of social inclusion, available (Rosengren, Orth-Gomer, Wedel, & Wilhelmsen, 1993).

Social relationships, particularly in a group context, impact our health in tangible ways. Groups play a role in people’s life satisfaction, experiences of stress, adjustment to change, symptomology of illness, health related choices, and responses to trauma (Jetten et al., 2012). A link has been identified between social support and psychological wellbeing (Sanderson, 2012). This can be a positive or negative association depending on the availability of support. Referring specifically to Christian social inclusion theologian Bonhoeffer said “Every principle of selection and every separation connected with it that is not necessitated quite objectively by common work, local conditions, or family connections is of the greatest danger to a Christian community” (2015, p. 37).

Conversely, social exclusion leads to a decreased ability to access employment, housing, education, and subsequently intensifies the presentation of symptoms for people with mental illnesses (Boardman, 2010). This is why solitary confinement is considered a severe punishment. In many countries social inclusion is now considered a key aspect of health and identified as a target in health policies, including a particular

emphasis on social inclusion for elder health (Coombs, Nicholas, & Pirkis, 2013; Department of Health, 2011; Newlin, Webber, Morris, & Howarth, 2015).

HOLISTIC HEALTH PERSPECTIVE

A sense of social connectedness, along with a spiritual outlook, contributes positively to an individual's physical, mental and social health outcomes (Aday, 1994; Galloway & Henry, 2014) and these are considered essential aspects of health from an indigenous Māori perspective (Durie, 2004b). Perspectives of health that focus primarily on physical well-being, or an individual's wellbeing without giving consideration to their context is neither holistic nor appropriate in a kaupapa Māori framework. The underlying philosophical assumption of narrative psychology is that human experience and behaviour is meaningful (Crossley, 2000) and that in order to understand ourselves we need to explore 'meaning' and the structures that create it (Polkinghorne, 1988). "What I am as a self, my identity, is essentially defined by the way things have significance for me. To ask what I am in abstraction from self-interpretation makes no sense" (C. Taylor, 1989, p. 34). However this approach to understanding 'self' is too individualistic to work within a holistic framework. Individualistic psychological and health perspectives fail to see the social impact on health and well-being (Jetten et al., 2012). Social health impacts carry over into other spheres of life, for instance, experience of sustained discrimination is damaging to a person's psychological and physical health and the impact is greater the longer the duration of discriminatory behaviour experienced (Clark, Anderson, Clark, & Williams, 1999; Jetten et al., 2012)

Complete health for the individual relies on the community health as well as individual health, with our culture and community interacting with our wellbeing and vice versa (Pulotu-Endemann & Tu'itahi, 2009). The Caring Community of focus in this research considers transformation of the individual and the community to be an integral part of the group wellbeing and identity (The Caring Community, 2014). Block (2009) states that transformation takes place when a community takes stock of the way they gather, the structure of gatherings, and when the focus of the group is depth of relationships over quantity and rapidity:

Community transformation calls for citizenship that shifts the context from a place of fear and fault, law and oversight, corporation and 'systems', and preoccupation with leadership to one of gifts, generosity, and abundance; social fabric and chosen accountability; and the associational life and engagement of citizens (p. 73)

SUMMARY

People construct their identities, relationships and meaning through language located in narratives. A particular emphasis on Māori approaches and faith-based perspectives on the topics of identity, participation, learning, belonging, and groups has been explored. Social identities and intergroup relationships are not just important for social service providers and health professionals to understand, they are a tangible tool that can be utilised, a potential strength for both individuals and communities to draw on when experiencing difficulties. Helliwell and Barrington-Leigh (2009) even go so far as to say that these social connections and places of belonging can be more beneficial to people than household income. When it comes down to it, trying to focus on all of these concepts within a community context is about creating a particular culture. “The future is created one room at a time, one gathering at a time. Each gathering needs to become an example of the future we want to create” (Block, 2009, p. 93). To further understand these topics in this unique context more research needs to be done that combines faith-based perspectives with social and psychological knowledge. More emphasis also needs to be placed on the participant point of view for various interventions and ways of being with one another.

Fisher (2012) reported finding few published studies on social justice group work carried out by faith-based groups. This is one example of the many ways that the current literature that is relevant to this topic exists in silos. There is a lack of research that crosses professional, cultural, theological and experiential divides. For us to understand more deeply how the interplay between mental health issues and social exclusion impacts future belonging, for example, there needs to be more research done that encompasses multiple aspects and experiences of groups of people. The other significant gap throughout the current literature is how the different perspectives of people from different backgrounds who interact with one another, impact each other’s experience of the phenomena like belonging, participation, and social-inclusion.

CHAPTER THREE: METHODS AND METHODOLOGY

INTRODUCTION

“The stories people tell have a way of taking care of them. If stories come to you, care for them. And learn to give them away where they are needed. Sometimes a person needs a story more than food to stay alive. That is why we put these stories in each other’s memory. This is how people care for themselves.” (Schulz as cited in Clandinin, 2016, p. 200)

In this chapter I explain my choice of narrative inquiry and analysis as most appropriate for this research. Underpinning my selection of narrative inquiry as a method of research is the resonance I feel with the ideas of Polkinghorne (1996), Bruner (1979) and, Crossley (2000) who argue that personal narratives construct people’s identities. I use the word ‘identity’ to refer to the knowledge and construction of self. Bruner (1979) describes humans making sense of life:

There is, perhaps, one universal truth about all forms of human cognition: the ability to deal with knowledge is hugely exceeded by the potential knowledge contained in man’s environment. To cope with this diversity, man’s perceptions, his memory, and his thought processes early become governed by strategies for protecting his limited capacities from the confusion of overloading. We tend to perceive things schematically, for example, rather than in detail, or we represent a class of diverse things by some sort of averaged ‘typical instance’ (p. 65).

As popularity has grown in the fields of psychology and therapy for narrative approaches, there has also been a parallel growth in the development and popularity of social constructionist research that focusses on participant narratives and the self as created within a context. This increase has also focussed around an attempt to have more equality in the roles of researcher and participant (Fenton & Baxter, 2016).

The Caring Community that I researched, and others like it, have a strong focus on relationships, and honouring one another’s stories. To not respect this innate community value would undermine the purpose of the community itself – sharing lives and sharing stories. I hoped that by using in-depth structured conversation with participants, we would go beyond the surface details that many may already see and are quick to judge, and gain an understanding of the construction of story over time and through experience. At its heart, narrative inquiry is interpretive (Frid, Öhlén, & Bergbom, 2000), through all stages and aspects of the process. In this chapter I describe and define the interpretive steps that I took,

the design and routes taken in order to uncover the stories and themes that were present in participant narratives. This includes describing processes used to obtain informed consent, and ethical considerations that were undertaken.

METHODOLOGY: NARRATIVE INQUIRY

Most broadly, narrative research is a qualitative approach to research (Polkinghorne, 1995). It is primarily concerned with people's stories, their own memories of their experiences, conveyed in a way that they have a degree of control over. Narrative inquiry sits under the epistemological umbrella of constructivism. Constructivism rejects the notion that there is one 'true' reality that is absolute and can be controlled and measured (Crotty, 1998). The constructivist view of reality is that it is created in relationship with one another and the world around us, and that it is not fixed but fluid in response to individual experience and context (Crotty, 1998; Lincoln & Guba, 1985). More specifically this research is carried out within a *social constructionist* view of reality, valuing the stories of individual humans as uniquely important whilst also being situated, and constructed, within a particular social and cultural context (Fitzpatrick & Kazer, 2011). Social constructivism is an expansion on the earlier interpretivist approach; however reality is considered to be constructed not by the individual alone, but via interaction (Crotty, 1998). This concept of reality being co-constructed is applied specifically in a narrative context by not considering the researcher to be a neutral sounding board, but rather a fellow human; the participant in dialogue with and where each voice informs and shapes the other (Polkinghorne, 1995). Because collaboration is inevitable in the telling of a story, with the reader/listener being an agent in the story, all stories are flexible; there is no one true representation of them. Instead, narrative researchers are trying to portray subjective experience of the participants, and knowledge and understanding from their perspective (DePoy & Gitlin, 2005).

Within social constructivism the inseparable nature of self and social structure is emphasised, and in particular the importance of language to the notion of self. This perspective assumes that our world is created through interaction with one another, meaning that language is a vital part of thought and expression. The narrative approach to research utilises story-telling as a way to convey participants' experiences to a broader audience, giving volume to voices that may otherwise not be heard (Riessman, 2008).

This research was carried out using the methodology of experience-centred narrative inquiry rooted in a Deweyan understanding of experience (Clandinin & Rosiek, 2007), which states that experience is

established within the interface of time and interaction (Dewey, 2007). Dewey's concept of experience underlies my approach, that experience is ever-changing as it occurs alongside, and intertwined with, our thoughts, our personal environments, our social contexts, our cultural and historical backgrounds, and not in a vacuum. In the words of Dewey (2005) "In an experience, things and events belonging to the world, physical and social, are transformed through the human context they enter, while the live creature is changed and developed through its intercourse with things previously external to it" (p. 247).

All of these contextual factors impact each person's reality, and therefore narratives. During our structured conversations I enquired into not only recent caring-community related experience but also elements of their early life, family, work history and any other influences participants considered relevant to their identity.

Many narrative psychologists believe that humans are inclined toward narrative modes of communication and thought from early on (Bruner, 1990; Mishler, 2003). It was appropriate to choose a qualitative approach to research for this study as the intent of the research is to gain greater understanding into these participants' experiences of participation in Caring Community. Many methodological approaches fit within the category of qualitative research including, but not limited to, grounded theory, phenomenology, narrative, action-research, and ethnography. A Narrative approach was chosen as that was ultimately what I was interested in; hearing people's stories. A place like the Caring Community I researched is concerned with seeing each individual for who they are, rather than attempting to generalise across the board. Many of its participants have had difficulties in the past due to their situations being assessed with a broad brush and Frank (2000) refers to this sort of discounting of someone's personal experience resulting in them feeling insignificant. Clandinin and Connelly (2000) spoke of the balance of self-identity and social identity when they said 'people are individuals and need to be understood as such, but they cannot be understood only as individuals' (p. 2). They are always in relation (Gilligan, 1982), always in a social context (Clandinin & Connelly, 2000). In order to know about their participation in the group and how it has been for them, I needed to hear them tell me their stories in their own words. Narrative research allows us to picture the participant's experience through their words (Coffey & Atkinson, 1996). The conclusion of narrative inquiry is a story, created between myself and the participant. To create these stories was not an objective process, but one born from the subjective relationship between us (Frank, 2005).

To comprehend other people's experiences I needed to first examine my own, and to interpret their experiences, I needed to first understand my own. It was inevitable that as I looked at topics of belonging, and participation that I would hear the stories participants shared with me alongside my own, noticing similarities and differences, remembering my own joy and pain that has come from belonging and loneliness. As I listened to the experiences of participants as relevant to this particular Caring Community, I also recalled my experiences with the Caring Community, and with other faith groups, which were both inspiring and frustrating. Story-telling is a medium through which we can re-examine phenomena we think we understand (Huber, Caine, Huber, & Steeves, 2013), and this is true for both the teller of and the listener to a story. I found myself seeing my experiences in a new light as I listened to the way participants had experienced similar circumstances differently from me. I also had the opportunity to see participants catch themselves as they were telling a story and remark on how something they said had surprised themselves. Clandinin and Connelly describe 'meeting ourselves in the past, the present, and the future' (2000, p. 60), and this was definitely a truism for me in this process. As I discuss further on in the Chapter four, it was my awareness of these parallels that meant I could notice them, note them in my diary, and also put them aside to focus on the participant and *their* experience, thus maintaining a rigorous approach to the study.

There are many reasons we tell stories, most relevant to this research is the way we tell stories to make sense and meaning out of our experiences (Bruner, 1990; Crossley, 2000; Engel, 1995; Riessman, 1993; Sarbin, 1986). Through this we develop our sense of self, and identity, and also our sense of self in relation to others around us. We also organise our experiences in a way that makes sense to us, in a way that we can find meaning that is either consistent with our view of self, or inspires us to challenge it. Viewing narrative in this role for humanity, validates the selection of narrative methodology for gaining deeper understanding of individuals' experiences in the caring-community. Narrative research was born out of researchers' experiences of encountering rich data in participant's narratives that was unable to be captured in other research methodologies (Clandinin & Connelly, 2000; Riessman, 1993). Narrative researchers obtain data through conversation, or interviews, with an emphasis on facilitating participants to tell *their* story and what feels important to them. Through the co-creating process it was my role to preserve the voice of the participant, rewriting their story in such a way that its integrity remained intact. Throughout the narrative inquiry process the researcher and participant are considered within a three-dimensional space. The three dimensions are temporality, sociality, and space; this means attention is

always backward, present and forward in time, inwards and outwards socially, and also on the space and context (Clandinin, 2016).

METHODS: SAMPLING METHOD

Narrative inquiry relies on participants' relaying of comprehensive stories from their lives, and so a small sample size is most appropriate. A flexible sample size of six to eight participants was chosen as I expected this to provide sufficient depth of data as the focus of narrative sampling is meaning and does not aim for generalisability. If there were more people interested in participating than required, then purposive sampling would have been used to select participants that represented the broadest range of people from the community. Integrity of the data collected should be considered by examining the depth of the data rather than the size of it (DePoy & Gitlin, 2005; Sandelowski, 1994)

Initially eight people were interested, and then one of those people did not contact me to further participate in the project so there were seven participants selected.

PARTICIPANT CRITERIA

Participants were required to be 18 or over, and to have been participating in the specific Caring Community for a minimum of 3 months. This ensured that they had what Hesse-Beiber & Leavy (2010) call 'specialised knowledge' of the research topic. Participants also needed to be willing and able to meet with me twice for 1-2 hours at a time and hold a conversation focussed on them and their participation in the group.

EXCLUSION CRITERIA

If participants met the above criteria the only exclusion criteria was to be on the basis of sampling. If more people were interested in participating than the specified 6-8 participants, then they would be selected on the basis of representing the widest range of people. Although there are teenage and child participants of this specific Caring Community, the study was restricted to adult participants for two main reasons. Demographically it was likely that many adult participants would be considered vulnerable and therefore I needed to pay great attention to the ethical issues that could arise. Furthermore, children are by nature more vulnerable to coercion by a powerful adult and therefore the decision was made to exclude them as I would not have been able to make sound ethical decisions with regard to all participants respecting each of their own specific circumstances and needs. The second reason is that as this study was

completed as a component of a masters qualification, the focus needed to be kept to an appropriate breadth and by restricting participation to adults I was able to do this.

RECRUITMENT PROCEDURES

Community participants were recruited through flyers at the group's main place of gathering and a one-off presentation by me to the group about the content, intent, and purpose of the research project. Interested people were invited to contact me by phone, email or text and were subsequently met by me to go over two information sheets. The first was the formal one with all information, and the second was a simplified, succinct version to aid with understanding and consent. These individuals were then given a 2-week time period, at the end of which they contacted me if they wanted to be considered for participation in the research.

The recruitment procedures were successful in that an adequate number of people responded positively and were willing to participate in the study, the recruits were also representative of a broad range of people from the group with a wide range of age, educational and employment histories, health status, sexualities and ethnicities.

PARTICIPANTS' CHARACTERISTICS

In order to protect the anonymity of participants from a small group in a small town, I will not discuss individual characteristics of participants in depth.

There were seven participants in this research project. The shortest length a participant had been a part of the community was 18 months, the longest was 4 years. All seven participants have had periods of weekly, or more, participation in community events and gatherings. All have participated at various levels of decision making processes within the group and so have knowledge of the specific culture, procedures, and nature of the researched Caring Community.

Four of the seven participants were female, three were male. The youngest participant was 26, the oldest was 71. Two participants were homosexual and five were heterosexual. One participant was Māori; six were of New Zealand European descent. At the time of the structured conversations four participants were married and three were not in intimate relationships. Three participants had spouses who also regularly participate in the same community group. Two participants had other immediate relatives who also regularly participate in the same community group.

Five of the seven experience significant mental or physical health issues that impact their life on a daily basis. At the time of the structured conversations one participant was in full-time employment, two were in part-time employment, three were unable to work due to ill-health, and one was recently retired.

All seven participants describe having an awareness of a spiritual aspect to life; some clearly articulated what this meant to them, some described themselves as practising a particular religion and/or denomination of faith, one was unsure what it meant to them, and another was a trained Christian minister.

All participants were able and willing to focus their conversation for 1-2 hours at a time on describing their experiences of encountering, and becoming a part of the Caring Community.

DATA COLLECTION: STRUCTURED CONVERSATIONS

Interviewing and recording (audio or video) are the most frequently used information-gathering strategies for narrative data in health and human services (DePoy & Gitlin, 2005). I have preferred the term 'structured conversation' over 'interview' because of the flexibility I desired in the conversation with participants. In order to obtain rich data I used questions that opened up topics and enabled participants to respond in ways, and with stories, that were meaningful to them. This also allowed the information given in response to previous questions to shape the nature and delivery of subsequent questions. I had two structured conversations with each of the seven participants. Each conversation lasted 1-2 hours and was recorded using a digital audio recording device. This approach allowed the participants some control over the direction of the conversation, and also facilitated depth of expression as they told their stories, rather than generalised third person statements (Riessman, 2000). The first conversation was guided by my asking the research question, further questions about topics of interest, and eliciting stories from the participants. The second conversation involved reflecting on the first conversation and what that was like for them, and anything that has been brought to mind as a result of reviewing the transcript and to draw out further stories that mark their participation in the group. Between conversations the participants had listened to an audio recording of the first, and I had provided a typed transcription of the conversation to be member-checked prior to the second structured conversation. The conversations were conducted in safe space as chosen by the participant, in their home, the gathering place of the Caring Community or the neutral space of a private meeting room at the local library.

Two of the participants requested to be spoken with together. I was apprehensive about this, but decided that this was participant focussed research, and that as the two participants were a part of one another's stories and that they requested for the conversation to happen together then I would respect that and do so. It was my experience that they provided rich data in the first conversation in a way that was made possible by the dialogue bouncing between the two of them, creating a full description of experiences they had shared. This helped with the co-construction of meaning between participants, and also with me as the meaning arose within the interactions between us, particularly as the roles of listener, and teller were swapped around during the conversation (Riessman, 1993).

Consistent with the research's ethical approval, collected data in its raw unanalysed form was kept confidential. Audio recordings were deleted at the completion of the project, prior to that they were stored on data stick in a locked cabinet and on a password-protected computer. Personal details of participants will be kept in a separate locked cabinet from de-identified research data which was locked away and stored on the password-protected computer.

Because I was already known to all participants, the focus of the beginning of my conversations was not the typical emphasis of rapport-building (DiCicco-Bloom & Crabtree, 2006), but rather taking the time to explain my need for them to be explicit about what they were saying, and my role in the conversation. It was important that participants understood that sometimes I would ask questions that they knew I would have some knowledge of their answer. This was not in order to pretend I didn't know but to make sure the information was available as data for inclusion in the study. I also needed to reiterate the difference in format between the structured conversation and a normal conversation, more specifically that I would not necessarily react to all things they said in a way that a friend might, because the conversation was not about me or my opinions. At times this felt awkward, particularly if they were referring to some action I had taken in a positive light and it seemed counter-intuitive not to note what this meant to me. This was also true as I listened to participants recounting painful memories, sometimes ones I was previously completely unaware of, and had to remain passive so as to not take hold of the moment and turn it into my story and also not to slide into the comfortable role of counsellor.

In the first round of structured conversations I was guided by my own pre-prepared conversation prompt. This was structured around the beginning, middle and end of a journey into Caring Community with each section containing possible questions that could help to draw out relevant stories. The beginning section was focussed on the individual and how they came to be in a space to explore intentional community. The

middle was about their early experiences of attending the Caring Community. The end section was focussed on their stories of belonging and participation. The conversation prompt also had a list of topics that I had drawn from literature to see if they had any relevance for participants.

In the second round of structured conversation I would begin by asking about any changes that needed to be made to the first transcript, including any sections that participants had subsequently decided they did not want to be included in the data for analysis. Then I followed up on what had struck them about the content of their first conversation and whether that had reminded them of anything else they wanted to share. I would test out some ideas I had about what the strong narratives were that ran throughout their stories, and sought participant feedback on the accuracy of those ideas from their perspective.

To honour the participants and the time they were gifting me, they were provided with café coffee and sweets at each conversation. The conversation were also commenced and concluded with a karakia in either Te reo Māori or English, by the participant, or myself, or both as desired by the participant. This was an opportunity to calm and centre our thoughts, label any anxieties, and to remember that all of our individual stories are part of a bigger story.

As it is not possible to be a neutral interviewer, it was therefore important to be aware of the influence I had on the conversation that I participated in (Mishler, 2003). Atkinson (2002) asserted that life-story interviewing “can be approached scientifically, but is best carried out as an art”. He also suggested that the interviewer needs to be flexible and adaptable. I took this attitude to the conversations and thus each one was different. The conversations were informal, and also intentional, through the initial research project presentation, the information sheets and my introduction to the first conversation participants were aware of what kind of data I was looking for (stories) and why.

DATA ANALYSIS

The rationale for using narrative inquiry as a research method is discussed earlier in the chapter, however due to the relative newness and ethos of it, the methods of analysis are not spelt out in a step-by-step approach (Lieblich, Tuval-Mashiach, & Zilber, 1998).

Narrative analysis relies on the identification of ‘diachronic data’, that is, ‘storied narrative’ (Polkinghorne, 1995). Diachronic data is narrative data that is temporal and refers to the sequencing of events, and the effects of one event on future happenings. Aristotle argued in his work *Poetics* that a narrative has a beginning, middle, and an end, unlike lists of occurrences. This is the loose format for

both the structured conversations, and the analysis and interpretation of data in this study. During analysis I will identify plots that link various aspects of the data. The end product of the analysis will be narratives summarising the plots contained within the gathered stories (Polkinghorne, 1995).

The epistemology and ontology of narrative inquiry are interconnected in that storied experience is the source of knowledge, and 'new' knowledge is created through the experience of going through the research process. The process of narrative interpretation begins with listening to the participants telling their stories, followed by the transcription of the conversations.

The participants' views were then compared with themes from the literature relevant to this topic, and explored in connection with the definitions of identity, belonging, participation and holistic health. Finally, implications for community groups, and community development were considered, along with gaps for further research.

The vagueness with which the analysis process was often described by other narrative researchers left me overwhelmed and anxious to say the least. However, I believe in the kaupapa and in the method and had to have faith in the process. Drawing on the writing of experienced narrative researchers (Clandinin & Rosiek, 2007; Crossley, 2000; Mishler, 2003; Riessman, 1993) was invaluable, both in the way they described the process in their writings about narrative approaches to research, and also in the way they documented their own narrative research.

NARRATIVE LENS

Narrative analysis is important because the process takes us beyond basic story-telling, and into a space where we create and find meaning through people's stories (Riessman, 2002). The purpose of analysis of narratives is to discover similarities across individual instances that can be viewed together as a bigger picture (Liamputtong, 2012).

Atkinson (2002) describes a view of 'truth' that is close to my own; that the meaning of the story told is more important than whether specifics are verifiable. This was an approach I was accustomed to using in my professional capacity as counsellor. It is not so much whether what I was told by the participants was the truth that mattered, but rather what mattered most it is how each particular part fits with the whole and what meaning is made of both the part and the whole. The Personal Narratives Group (Barbre & Group, 1989) describe this stance as follows

When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths. These truths don't reveal the past "as it actually was," aspiring to a standard of objectivity. They give us instead the truths of our experiences. (p. 261)

The story is reshaped, remoulded, and then retold as a modified story, one that has been co-created for the purposes of a deeper understanding. To carry out this process the data is viewed through the researcher's 'lens' or frame of understanding (McCormick, 2004). For me this lens was created through an awareness of my own beliefs and pre-understandings, my professional background as a counsellor and mental health worker, my theoretical knowledge of narrative research, and my theoretical stance that identity is co-created through experience in a particular context and the narration of these experiences (Rosenwald & Ochberg, 1992). My own awareness and experience of structural injustice and power dynamics meant that I was aware of subtle reference to injustice and abuse. My professional background meant that I was aware of reference to feelings and incongruence between participants expressed values and actions, and ambivalence around engagement with the group (Miller & Rollnick, 2002). My theoretical knowledge and stance strengthened my view that there is value in hearing other people's stories; that they are worthwhile in their own right, and that we can learn directly from them.

MODES FOR READING A NARRATIVE

Lieblich, Tuval-Mashiach and Zilber (1998) have proposed four modes for reading a narrative. These are created using the four ends of the two dimensions: form vs content, and holistic vs categorical analysis. A holistic approach to analysis is when parts are understood in relation to the whole, a categorical approach is when a participant's story is divided into parts based on themes. A focus on the form of a story considers the construction, plot, tone, style, complexity and coherence. A focus on the content of the story considers what the narrator said happened and what feelings and thoughts they had about it. Lieblich et al. (1998) combined the sub-dimensions to form the four modes of reading a narrative; 'holistic-form', 'holistic-content', 'categorical-form', and 'categorical-content'.

Although Lieblich et al (1998) suggested that researchers tended to find they were drawn to one mode in particular, I found that they all felt natural at different times and it was more helpful for me to view them as tools to approach each reading from a different mode and note all the responses and insights I had for each story using each mode. Because of this approach, the method of analysis that emerged for me was a balanced mix of all four modes.

DEVELOPING A METHOD OF ANALYSIS

Analysis began with the transcribing of the structured-conversations. I elected to do this myself, both to protect the information given by participants, and to utilise the opportunity to familiarise myself with the data. However as in Riessman's (1993) description of five levels of analysis of narrative data, the first three, attending, telling and transcribing, give an incomplete understanding; that the information is partial and selective. It is in the final two levels, the analysing and reading, that meaning is found. Different ways of analysing the same transcription will result in varied meanings, as Stivers et al (1993) say I am aiming for "believability, not certitude, for enlargement of understanding rather than control".

'Mapping' was a commonality through many different narrative researchers approach to analysis of data (Crossley, 2000; Polkinghorne, 1995; Tuval-Mashiach, 2006). Crossley (2000) developed a six step process for analysing narrative data and transforming it into storied form. I needed some guidance around the details of the narrative analysis process and Crossley's six-step method fit well with my desire to take an integrative approach to analysis and to not get too stuck at either end of the continuums mentioned above (Lieblich et al., 1998).

I used Crossley's six step approach as outlined below as a process of analysis and interpretation of the data obtained from the structured conversations with participants. It was as I used this process that I was also reading through the data using each of Lieblich et al's (1998) four modes of reading.

STEP 1

I read through transcripts thoroughly four or five times. During these readings I kept note of all common ideas, or threads of stories that were standing out to me. I handwrote notes in the margins and spaces of the ideas and themes. I also used highlighter pens to mark significant words and phrases. A theme (Crossley, 2000) is defined as any repeating, or significant 'patterns of motivation' which also includes inconsistencies.

STEP 2

I identified common ideas and topics in each narrative. This was partly done at the completion of both structured conversations, but was also co-created with participants in the second round of structured-conversations as I checked out some of these ideas and topics I had noted from our first round of structured conversations. On separate sheets of paper from the transcripts I started to create one mind-map for each participant of the ideas and themes I was identifying.

STEP 3

The purpose of step 3 was to take note of the tone used by the participant in various parts of their conversation. An example of this was making note of whether participants used an ‘apprehensive’ or ‘enthusiastic’ tone when they were describing initially exploring the Caring Community.

STEP 4

Crossley (2000) found that imagery and themes tended to be related and at times be intertwined. Therefore it was important to analyse them together focussing on cultural symbols and language, and repeated ‘patterns of motivation’. At this point I noticed that words I had initially thought represented unique themes, for example ‘family’ and ‘community’, were actually part of one theme for that participant. As a result, step 4 involved shuffling around themes and sub-themes in the mind-maps for each participant as it became more apparent how they fit together.

STEP 5

The fifth step was about beginning to collate themes, imagery and tone. At this point I considered various researchers’ approaches to mapping stories and using an eclectic approach to these created a table for story-mapping for this particular research. Lieblich et al (1998) proposed that mapping themes should be done within a theoretical model. Marshall (2005) followed this approach within the theoretical framework of occupational therapy, and inspired by this I developed my own chart from the theoretical perspective of holistic health. Richmond (2002) also used a grid-form story map approach, with an emphasis on unearthing sub-themes from within the overarching themes. Polkinghorne (1995) described using a story map to uncover the ‘voice’ or plot of the narrative. To order my observations and put data into the tables, I went through the transcripts many more times colour-coding with highlighter pens as I read. The purpose of qualitative narrative research is to focus on individual’s stories and perspectives. Bruner (1990) stated that this doesn’t preclude the chance of common themes emerging, and this is consistent with a Te Ao Māori perspective on communal experience. With that in mind I kept my overall thematic map sheet updated.

STEP 6

This step involved pulling together the identified themes into a core narrative with a beginning, middle and end, the re-presentation of the data as an interpretive story (McCormick, 2004). Each participant’s core narrative was assigned a title that came out of either the themes or the specific words used by the participant to sum up the created meaning of the story (Polkinghorne, 1995). I then wrote sub-narratives

for each participant that were grouped under thematic headings. These were chosen on the basis of being the most common themes across the participants' total data. Over the six steps described by Crossley (2000), my processes of annotating, highlighting and colour coding enabled me to identify the data that needed to be pulled together for the final story. Not all data was included in the story as it was not all significant in my endeavour to gain understanding of peoples' journeys into Caring Community. I also needed to focus on a manageable amount of data, so some subthemes identified were not included on the basis of their infrequency. This process of data selection is referred to as 'narrative smoothing' by Spence (1986). I took care to stay true to each participant's style of narrating and the language they used as recommended by Grbich (1999).

ANALYTICAL TOOL

In order to keep track of everything that I was finding in the processes described above, I adapted various charts used by other narrative researchers (Marshall et al., 2005; Richmond, 2002) and created one to use for this research. A chart was used for each participant. This allowed for me to make and collate notes from the four reading modes (Lieblich et al., 1998), the 6 steps of analysis (Crossley, 2000), and the different aspects of my personal 'lens' of analysis (McCormick, 2004). I also used the chart to refer to themes that had been chosen as relevant theoretically; social inclusion, participation, belonging, holistic health, and identity. The purpose of using this story-mapping tool was to keep track of, and organise, the ever-growing amount of information as I progressed.

STUDYING NARRATIVE FORM

Narratives have a stylistic flow and each is uniquely constructed. Looking at these aspects of the narrative is considered to be studying the 'form' of the narrative. To help me to do this I have utilised the following five questions used by Marshall (2005). The purpose of each of these questions is reviewed in the subsequent sections.

CORE NARRATIVE: WHAT IS THIS STORY ABOUT?

The question 'what is this story about' invited me to explore what were the main ideas in the narrative, the overall plot. It was also an opportunity to pay attention to how the participant presented themselves. These core narratives were re-presentations of the 'whole', a summary to introduce the narrator and their story, and they are discussed in Chapter Five.

NARRATIVE DIRECTION AND STYLE: WHAT KIND OF STORY IS THIS?

Sometimes narrative researchers use genre as a tool of analysis and categorise narratives into typical genres (De Fina & Georgakopoulou, 2015). I wanted to approach participant's narratives with an attitude of curiosity and was concerned that if I had a set number of boxes to attempt to place them into I would be manipulating the meaning beyond a useful level. Therefore, I used an open-ended question to approach the issue of direction and style, 'what kind of story is this?' In answering this I was looking at the direction of the plot, where was the story going? I was also paying attention to the style it was narrated in and the tone of narration.

NARRATIVE VOICE: WHO IS TELLING THE STORY?

The question 'who is telling the story' focuses on the identity of the narrator, in the case of this research, the participants. I was looking at the particular language of the participant during our conversations, the use of humour and metaphor for example and the attitude conveyed through voice and language. Sometimes these attitudes were about experiences, and sometimes they were about themselves and this was particularly relevant to this section about identity. I paid particular attention to when there were shifts in language, for instance from more general statements to direct 'I' statements. I also noticed when feelings were verbally articulated, or emotion was carried by the tone. One other way the participant would change the way they presented themselves was with regard to temporality; I recorded when they were speaking about the past them, or the present them, or a potential future them.

VOICES OF OTHERS: WHAT DOES THE NARRATOR SAY ABOUT OTHERS?

In keeping with the theoretical perspective of a socially-constructed identity the question 'what does the narrator say about others?' helped me to take note of where the participant placed themselves in relation to others. This changed depending on who they were speaking about, other times there was a visible consistency to how they saw others, or saw themselves in relation to others. Participants would also give voice to other people, or characters, as they told their story, and through articulating this it was possible to gain insight into the way that people shape their own identity through their interactions with others.

CORE MESSAGE: WHAT CAN WE LEARN FROM THIS STORY?

Sometimes participants were conveying a clear message, other times it was through the analytical process that a fundamental idea was deduced. The question 'what can we learn from this story' was about uncovering and presenting this truth, or message, or idea.

STUDYING NARRATIVE CONTENT

Continuity [is] the idea that experiences grow out of other experiences, and experiences lead to further experiences. Wherever one positions oneself in that continuum – the imagined now, some imagined past, or some imagined future – each point has a past experiential base and leads to an experiential future (Clandinin & Connelly, 2000, p. 2).

The main purpose of this research was to analyse individual narratives for emerging themes and ideas, and I also wanted to be alert to overall themes emerging (Bruner, 1979) so in analysing the content of all participants' stories I looked for unique and common themes and these are discussed in Chapter four and five.

RESEARCH RIGOUR

Rigour is used to assess the quality, trustworthiness, and integrity of qualitative research and the processes implemented within it (Tobin & Begley, 2004). The constructionist ontological position is that there are multiple realities; therefore it is necessary to assess whether the presented reality is an authentic representation of the realities of the participants (Carpenter & Suto, 2008). I achieved this by the presentation of my reasoning in the selected representation of the narratives of participants (Lincoln & Guba, 1986; Padgett, 2008). My own participation in the community contributes to data credibility due to the recorded phenomenon of decreased incidence of participants withholding information or being deceptive when talking with a researcher they know (Fetterman, 2010; Padgett, 2008).

The narratives produced through the analysis were an emplotment of events that can be supported by the original data (Sandelowski, 1991). The insight gained in narrative research is from story-telling and re-telling, rather than the predictive abilities of a conclusion. This insight was only possible through retrospective accounts of events, and so any conclusions drawn were matched to the original data.

Rigid rules for the establishment of rigour are not appropriate in a narrative inquiry study, instead a set of values that are reflective of the kaupapa of qualitative research: “attentiveness, empathy, carefulness, sensitivity, respect, honesty, reflection, conscientiousness, engagement, awareness, openness, context” (D. Davies & Dodd, 2002, p. 288) were used. This set of values is consistent with the values of the Caring Community set out in their book of ‘Community values and practices, tikanga and kawa’ (The Caring Community, 2015).

According to Angen (2000) making all aspects of the research process transparent and open makes the research more trustworthy. To ensure rigour in this research I have documented all steps of my process as fully as possible.

TRUSTWORTHINESS

Trustworthy research needs to be carried out ethically and openly in order to most closely reflect the participants' stories so that the stories are given due time and regard by the reader. Consideration of ethics is an essential element to designing and carrying out trustworthy research (D. Davies & Dodd, 2002).

I maintained monthly phone supervision sessions, which helped me balance the insider and outsider roles of participant and researcher. I aimed to be trustworthy in my relationships with both academia and with the Caring Community, and supervision was a safe space for me to explore any ethical issues with regard to both sets of relationships. Supervision was also a space where I was held accountable for my decision-making around which elements of the data could be focussed on.

The process of making the tone of the stories true to the personalities and lives of the participants was also aided by my ongoing participation in the Caring Community. While I did not engage in research with the participants at community events, informal conversations kept the tone and cadence of their forms of expression alive for me. Informal contact also ensured I saw the participants as full people, and did not reduce them to the stories they had chosen to share with me during the two structured conversations.

REFLEXIVITY

Reflexivity acknowledges the role that I, as researcher, play in the interpretation of data, and, from a narrative inquiry perspective, the role that I play in co-constructing the data (Angen, 2000; Hesse-Biber & Leavy, 2010). Member-checking of the transcript, and the second conversation allowed me to review the assumptions I made as a result of the first conversation. My own reflexivity, established through critical reflection on my 'self as researcher' (Lincoln & Guba, 1986) contributed to credibility and rigour of the research. I established this through conversations with my supervisors and by maintaining my corporate and personal spiritual practices. Having been trained since childhood to use daily prayer and contemplative discussion as reflective spiritual practices this was a natural process for me. Clandinin and Connolly (2004) use the term 'wakefulness' to describe the narrative inquiry attitude to research. Wakefulness refers to ongoing reflection and the challenging of assumptions, a thoughtful process of decision making, and is considered the most needed attribute of research. Frequent communication with

my research supervisor, professional supervisor, and proactive maintenance of my own mental and spiritual health facilitated my ability to remain wakeful throughout the research journey.

As I embarked on the analysis process I used a reflective journal to record my thoughts, feelings, questions and challenges I was experiencing in response to the participants' stories. This was particularly useful for me as I was unable to discuss the content with those around me for ethical reasons, and so it gave me an outlet to process my feelings. It was also a place for me to record questions I had for myself about what I thought may be emerging but didn't want to pre-empt. In this way it served as a place to store my thoughts to return to at an appropriate part of the process.

I found an additional source of informal support through a New Zealand facebook group for writers who are mothers. This was a source of great motivation and comfort for me, being able to learn from other women with multiple roles to juggle. I was also able to ask for help when I couldn't find a way to articulate my thoughts.

PERSUASIVENESS

Riessman (1993) challenges the narrative researcher to ask of themselves, "is the interpretation reasonable and convincing?(p. 65)" It was important to me that the stories I wrote were congruent representations of the voice of the participants. Clandinin (2016) wrote of the awareness of both the participants and the possible audiences as you co-construct the stories in narrative research, "however research texts are negotiated with participants , who remain the most influential voice in the move to final research text... we owe our fidelity first and foremost to sustaining research participants (p. 205)." I needed to write persuasive stories for each participant, ones that respectfully represented their voice, and could be linked to the raw data. An important part of making sure I did this, was going on a 4 day writing retreat with a chaplain. I worked almost solely on the participants' core narratives during this time and it was invaluable for me to be able to check whether the tone of each story represented a different person. I was also able to establish that I had not told other people's stories through *my* voice, but rather that I had written their stories whilst maintaining the integrity of their own voices.

ETHICAL CONSIDERATIONS

In narrative inquiry, inquirers must deepen the sense of what it means to live in relation in an ethical way... Ethical considerations permeate narrative inquiries from start to finish: at the

outset as ends-in-view are imagined, as inquirer-participant relationships unfold, and as participants are represented in research texts (Connelly, 2006, p. 483).

Vulnerable populations are those groups that are considered to have increased risk of, or are particularly prone to, having a lower quality of life and negative health outcomes (Flaskerud & Winslow, 1998). Vulnerable populations are significantly more likely to have experienced discrimination, intolerance, stigmatisation and marginalisation than non-vulnerable groups (Carlisle, Leake, Brook, & Shapiro, 1996; Galloway & Henry, 2014; G. D. Smith, Neaton, Wentworth, Stamler, & Stamler, 1996). Therefore there are particular considerations that need to be made when conducting research that involves vulnerable people groups (Nordentoft & Kappel, 2011). Many of the community group participants may be considered vulnerable for reasons due to mental illness, physical disability, gender, ethnicity, sexuality, education, illiteracy or homelessness. Conducting the research conversation in a neutral space that is private, and nominated by the participant, contributed to their sense of safety, and I sought supervision around any perceived areas of participants' vulnerability.

The Belmont Report (National Commission for the Protection of Human Subjects of Biomedical Behavioral Research, 1978) commissioned in response to unethical 'research' conducted during World War II, describes three principles now adopted around the world for research with humans: autonomy, beneficence, and justice. Narrative inquiry as a methodology provides space for participants to have autonomy over the information they provide, particularly important for vulnerable participants (Walsh, 2009). In the event that the sharing of their stories triggers psychological distress, provision was made for counselling to be accessed through a local counselling centre demonstrating a commitment to the beneficence for participants. This study has been designed with the potential benefits to the participants and the group as a whole, showing a just approach to research. In order for the community to exist in a way that promotes pro-social and positive health outcomes, it first needs to be established what the experiences of participants are.

Comprehension of the implications of participation, for both the participants and the researchers, is vital and gathering informed consent from vulnerable groups of people is more complex than literature implies (Nordentoft & Kappel, 2011). Many in the community group have impaired comprehension due to mental, cognitive, or literacy reasons. Therefore it was important that I avoided unnecessary complexity when explaining the study and obtaining consent. Information for this study was provided in full written form, in a more simplistic written form, and was read through with all potential participants. After

volunteering to be part of the study, potential participants had two weeks between provision of the information and meeting to obtain consent. This enabled the volunteer to read through the information in their own time and access additional help if required without experiencing *whakamā*.

While sharing their stories, and being listened to non-judgementally, participants could have developed a close relationship with the researcher. This emotional proximity had the potential to result in the participant sharing information they would have considered confidential and not for research (Lawton, 2001). Consequently, provision of consent was an ongoing conversation and participants were given their transcripts and audio recordings of the first structured conversation to review. Throughout this thesis the participants are identified using a pseudonym to maintain confidentiality.

To reduce the power differential, participants were also invited to ask the researcher any questions they had about the researcher's own experience of participation in the community. Stanley and Wise (1983) use this as a way of putting participants 'at ease'. Providing this opportunity also honours the reciprocity and mutuality that marks genuine and authentic connection and relationship. This meant I was congruent with the values of the Caring Community. Despite the ethical considerations required when working with vulnerable populations, it is important that such studies are carried out. Vulnerable people are often excluded from research that could have been to their benefit following decisions that purport to be in their best interests, and are therefore further stigmatised (Aldridge & Charles, 2008). Due to being a part of the group myself, I acknowledged that I would have dual-relationships with the study participants. A recent study found that though this is increasingly common, literature about dual-relationships in research is scant (McConnell-Henry, James, Chapman, & Francis, 2010). Four phases in the development of rapport have been described by DiCicco-Bloom and Crabtree (2006). The fourth is participation, and it is only when the fourth phase is reached that the elicitation of information occurs. It has been proposed that when participants and researchers have a pre-existing relationship, rapport building is fast-tracked, leading to the obtainment of 'rich data' and that "the opportunity to interview a participant with whom we share a dual-relationship is one of great privilege" (McConnell-Henry et al., 2010, p. 8). Others argue that a pre-existing relationship can cause role confusion, or confusion about the nature of the interview (Manderson, Bennett, & Andajani-Sutjahjo, 2006), but it is my belief that through careful explanation of the process, and transparency, this can be avoided. The presence of a pre-existing relationship also acted as a levelling agent of the power differential due to the mutual expression of vulnerability. Asselin (2003) states that the possibility of role confusion can be mitigated by preparing well for research through provision of accurate information to participants and clarity for the researcher and participants around expectations.

Studies indicate that the kind of stories someone tells about events of their life can actually impact their general well-being (Gergen, 2004). Gergen's study, "Once upon a time: A narratologist's tale", found that elderly who told stories of voluntarily ceasing activities were 'healthier and happier' than others who told stories of being forced to give them up (2004, p. 270). Another study (McAdams et al, as cited in Marshall et al., 2005) found that stories told by people that focussed on them overcoming a negative event were positively associated with satisfaction, self-esteem and negatively associated with depression. Altering your interpretation of a 'negative' event into a positive one, known as reframing (McLeod & McLeod, 2011), is a tool implemented to build resilience. Consciously forming, or re-creating, personal narratives provides an opportunity to disrupt potentially significant consequences of negative life events.

TE TIRITI O WAITANGI

Aotearoa/New Zealand is a country of diverse people, and multiculturalism is evident in all areas of New Zealand. The legal heritage is one of biculturalism, founded on Te Tiriti o Waitangi, (The Treaty of Waitangi, 1840) a contract between Māori, the indigenous people of Aotearoa, and the British Crown on behalf of British colonists. The Royal Commission on Social Policy (1988) described the three principles of Te Tiriti o Waitangi as partnership, protection, and participation. Auckland University of Technology (AUT) honours the principles of te Tiriti o Waitangi which is integral to its culture stating "The overall aim for AUT is to imbed the Treaty of Waitangi principles within AUT's core business (Auckland University of Technology, 2016)". The Caring Community of focus is also committed to biculturalism as stated in their culture and values book (The Caring Community, 2015). I also have a deep personal commitment to biculturalism in Aotearoa, and held it personally important to uphold the principles of te Tiriti o Waitangi in this research.

In Margaret's book (2013) about cross-cultural work as a Pākehā, she discusses themes around the challenge of working cross-culturally, which includes building and maintaining trust, respecting difference and managing conflicting expectations. In this way I was aware that much of the ability for me to research in a culturally appropriate way had already been decided. To build and maintain trust takes time and genuineness. This cannot be scheduled into a research project timetable. My commitment to ongoing, albeit slow, upskilling of my te reo Māori, and awareness of the structural issues that Māori face on a day to day basis were important in this project. There were times that Tipene struggled to articulate his feelings and experience in te reo Pākehā, and it was in these moments that understanding a concept

expressed in te reo Māori conveyed both my commitment to the protection of the taonga of reo Māori, and facilitated the natural recall of the participants' experiences.

All New Zealand research impacts Māori (M. Hudson, 2010). Both the Caring Community and I have a strong commitment to upholding tikanga Māori. Smith (2012) says of Māori, 'We have a different epistemological tradition, one which frames the way we see the world, the way we organise ourselves in it, the questions we ask and the solutions that we seek' (p. 190). Narrative inquiry allows the participants to frame their story in the way they have experienced it, and this is consistent with the worldview described by Smith. Smith (1992) describes a 'power-sharing' model of Māori research where researchers engage with the community to support the research in a meaningful way, exercising 'partnership' (Tiriti o Waitangi). Māori participants and the cultural advisor of the Caring Community were consulted throughout the design process to ascertain the design's appropriateness and reflect the treaty value of participation.

In his second structured conversation with me Tīpene reflected on the individualistic nature of my question about the impact of participation on his health and wellbeing. In the first conversation he had struggled to answer that, and as he reflected on that with me in the second conversation came to the realisation that it was because he doesn't think of himself in an individualistic way. Once I reframed the question from a collective whānau orientated stance, he was able to identify the impact of his participation on his whānau.

Manaakitanga and aroha were expressed through the provision of coffee and kai whilst participants share their stories. In 1991 Barlow described this in the following way:

Ka tae mai he tangata ki tō kāinga, mihiā, ā, whāngaia ahakoa he kapufi noa iho. [When visitors come to your home, welcome them and offer them something to eat, even if it is only a cup of tea.] (pp. 7-8)

Te reo Māori will be used in karakia tīmatanga and karakia mutunga for those participants that desire it, and this is in acknowledgement of Te Tiriti o Waitangi principle of protection of the taonga reo, and also to acknowledge the role spirituality and faith play for some participants. The guidelines for Māori research ethics emphasise the importance of benefit sharing, that positive outcomes of research may be experienced by participants, society, and researcher; by Māori and Tauīwi alike. This study aims to benefit Māori by gaining insight into Māori participants' experience of belonging and what contributes to

that, also by expanding the voice of Māori experience in literature. This is a reflection of the function ‘tohitohia’ (the ability to share) from Durie’s (2004a) Māori ethical framework, Rangahau painga.

SUMMARY

Chapter three has described the methodological processes I undertook in order to carry out this research. Narrative inquiry was selected as the appropriate methodological fit for research that focussed on the experiences and recollections of participants within the Caring Community. The research has been participant-focussed with a commitment to presenting participants’ stories in a way that respects both the stories and the participants.

CHAPTER FOUR: SHAPING THE STORY

INTRODUCTION

Chapter four contains my re-telling of the stories the seven participants shared with me. The main story that hangs around a particular theme for each participant is presented first as their core narrative. Subsequently sub-narratives are grouped by overarching themes. The style of each story is slightly different in an attempt to preserve the voice and integrity of each participant.

CORE NARRATIVES

TĪPENE'S STORY: A STORY OF SAFETY

Tīpene is a Māori man in his 50's. He lives alone and spends much of his time involved in church activities. Tīpene's early years were difficult for him. He spent time in various different living situations including many foster families. Tīpene's childhood was not a time of safety; homes, schools, and churches housed many unsafe and abusive experiences for him. He described himself as a 'very angry young man', at times necessitating that the classrooms be cleared for others' safety. As he grew up he was painfully shy, bursting into tears every time he tried to speak in public. This was not helped by the time, when he was 8 that he drank turps and burnt his voice box. Despite his shyness, he found a place for himself within various leadership roles within churches. Once he became a minister, he felt as though everything went downhill. Church members held the view that "ministers couldn't do anything wrong" and that they were expected never to ask for help. A week before he was ordained Tīpene asked for prayer, sharing that he was going through a difficult time and proceeded to be ridiculed for an hour in front of the congregation. He remembers thinking "I don't need this, I need them to come and help!" and yet ministers were considered to have something wrong with them if they needed help. Because of Tīpene's history with churches he is familiar with a very hierarchical approach to leadership and has found the Caring Community's style of equal participation and leadership "very unique". The thing that Tīpene really remembers about turning up to the community group the first time, was being asked if he would like to say grace. This meant a lot to him, the fact that the group had put their trust in him, someone they didn't know. He recalls thinking, "we need to put that trust in people" and he tries to do that now and not be "so controlling". He considers it to be dangerous but necessary to put trust in people saying it is "the right thing" to do. He has also noticed that when he does this people come out of themselves, like when he was asked to do grace, "it's a small thing, but it's a big thing". Tīpene has also

experienced “a lot of condemnation” and judgement in churches he has been a part of. He describes the Caring Community’s approach as one of “lifting up” each other, acknowledging mistakes and supporting each other to grow. He remarked that issues and conflict get dealt with in a quick manner and considers that the community’s culture booklet facilitates this by describing what the standard of behaviour is within the Caring Community. He likes the positive focussed approach to dealing with conflict that is used, for instance asking people who are stuck in an angry space to name 3 positive things from their day. He prefers this to his experience elsewhere where people have been banned or “kicked out” from groups, as “9 times out of 10 they don’t come back”.

The love that Tīpene has seen expressed between community kaitiaki has given him a sense of safety. He has developed a practice of watching the leadership of groups to see the nature of their relationship with one another in order to determine the values and culture of the group. He has used this as a gauge for safety saying that if the relationships between kaitiaki are OK, then it is safe to trust what they say and to listen to them. He has also seen the kaitiaki express this love for the others in the group, particularly when they address an issue by “going straight to the point” by naming the issue, and then he has watched the issue “just disappear”. He recalls a particular instance between two people, who were arguing in a way that involved yelling, swearing and spitting, and they were approached by kaitiaki and it just “calmed down”. He says that if this had happened at another group he is a part of then “chairs would have been thrown”. Both the way that issues were named and the love of the kaitiaki became very important to Tīpene personally when a complaint was laid against him. One of the kaitiaki “came straight to” him and told him that the complaint had been laid and what was happening about it. Tīpene had someone lay the same complaint at the other group and was “kicked out” for 2-3 weeks with “no explanation” and recollected his appreciation at being included within this Caring Community’s process. This period was “hard, really hard” for him, especially continuing to come to the group, but because he was included he felt able and safe to do so.

Tīpene recalls all of his foster homes being ‘Pākehā orientated’ and that he was unable to learn his own language because people viewed it as ‘satanic’. He finds his expression of his culture to be more prominent now, especially since coming along to the community group where he says it has been reinforced. He no longer holds on to the stigma attached to Māori culture and language that he had been brought up with. Despite having worked with other Māori pastors previously, Tīpene refers to this Caring Community as the “only place where... they encourage the Māori side of things”. It was when he was asked to consider helping lead the te reo Māori service that he really started to express his Māoritanga.

When he first started he felt very “whakamā” but having other people, Pākehā people even, using te reo Māori words and having te reo Māori signs in the kitchen helped acknowledge the space for Māori. Tīpene has never experienced any “put downs about Māori” in the group although he heard that one day someone made a negative comment about the use of te reo Māori and its use was explained to them. Because of these things, and also because the use of Māori waiata and karakia, Tīpene considers the Caring Community to be a safe space for others to explore their Māoritanga and hopes that there will be further opportunity in the future for people to extend their knowledge. He also feels that people are accepted wherever they are at in their journey of being Māori.

The main part of the Caring Community that created a sense of safety for Tīpene was the culture and values booklet, and particularly the kupu Māori used within it. Tīpene finds it much easier to give to others than to receive help. Because of this, Tīpene has been discovering the place of “learning to step back” within his well-being. He has found himself drained and has been realising that being healthy means knowing what is a safe level of ‘stuff’ to undertake. He has begun to explore what his limits are in terms of experience and his own stress levels. The relaxed nature of gatherings of the Caring Community, and the love that he has experienced have meant he has felt safe enough to let go of some things he has perceived to be outside of his space of health. During this time of exploration he was asked by one of the kaitiaki “what can we do for you?” This was a significant experience for Tīpene as he had never been asked that before and someone was asking his opinion rather than telling him what he should do. It caught him “off-guard” but felt respectful of his own ability to know what he needed. Tīpene feels as though many people in ministry contexts forget to do this, thinking they need to be there for everyone every time, and try to keep the issues “in house”. He now views knowing these limits as a way to create safety for himself *and* for others.

JONATHAN’S STORY: A STORY OF GIVING AND RECEIVING

Jonathan is a Pākehā male in his 60’s. He spent much of his working life as a civil servant and would like to be working now but has struggled to find work largely due to his struggles with mental health diagnoses. He has been a Christian all his life, having grown up in a Christian family and continuing to be actively involved in churches throughout adulthood. Contributing to church life through various roles on church boards and management committees has been important to him. Jonathan initially moved to this town after an allegation against him made remaining where he was untenable. He responded to a friend’s request for help to run a local farm and went to stay with them, helping with various problems in

the home. When that concluded he got in touch with someone from the Caring Community and came to live in a house the person owned for the purpose of people in need to share with others who were participating in the community at that time. Through this Jonathan was invited to evening meals at one of the homes of a kaitiaki. He was used to small country congregations where people did “everything together” and believes this is how God intended us to be. Early on he was struck by the “number of people involved positively” noting that there were many motivations for people to be involved including self-interest and also altruism. He likened this to the Amish where, “community helps the community and it’s of benefit to all.” Jonathan also drew a distinction between another group that he attends that “does things for people with very little return” and this group that “helps people to do things together, that we bring our own food and share”. He has found that this is a major difference in attitude, despite many of the same people attending both groups. He believes there is a lot of people who consider it their “right to have it [a free meal]”, and that for some that’s their lifestyle and for others it’s a phase. He says that people are encouraged to give in a way that they can, like tidying up or helping in the kitchen. He notes that there isn’t an expectation that if someone comes they will help out.

For a long time Jonathan’s “tagline” has been “improve yourself by improving your community”. He believes that everything “gets better” when the focus is on improvement of the community. He has also seen this in action through the volunteering he has done with Habitat for Humanity. He saw people coming together to improve one person’s life and those improvements flowing on to the neighbours, “that’s a good thing”. About the time Jonathan began being involved in the Caring Community, it was involved in running a community garden in partnership with a government organisation, and he remembers working in the garden to help provide vegetables for meals and the foodbank so that “the community would benefit health-wise”.

As well as giving to the Caring Community, Jonathan has also been able to receive from it. He has been assisted by other participants to shift house twice. He remembers it being a great help to have people, and vehicles, and trailers available at short notice. This was of benefit to him mentally, physically and financially. He has also been spiritually helped by the group through its “prayer and praise sessions” and through the presence of other people who are guided by the same spirit as him. The mutuality of helping; the giving and receiving, has also been a spiritual lift for him. “It’s just helping out as can be, and supporting as can be”. Other times he has appreciated having people from the Caring Community that he can go and talk to safely, knowing that their attitudes are similar to his, and he has found this a rare experience even within churches.

Jonathan strives for social change in the community. He believes that the “best way of changing behaviour” is to “catch ‘em when they’re good”. He has found that if you help those around you then they “see you in an improved light” and that this encourages you, and you go on to encourage each other. This is the way that he approaches his involvement in the Caring Community, saying “every time I’ve been helped, I try to help back”.

STEPH’S STORY: A STORY OF COMMITMENT

Steph is a Pākehā female in her 20’s. She currently works in a sales job she neither loves nor “is good at, at all”. She grew up in an actively Christian home, but from the age of about 11 stopped attending church. She doesn’t know if she believes in God, thinks Jesus is “a cool dude”, and views the Bible as a useful resource. She is certain there is something spiritual and gravitates toward spiritual things but is still trying to work out for herself what that means for her. She notes that there were many significant factors in her childhood that she has “discarded” but that religion and faith have “stuck with” her and she still considers them important and comforting, and draws on her spirituality when she is distressed.

When Steph came to this town, it was to stay with family as she didn’t really “have anywhere else to go”. It was never her intention to stay and she could not understand why anyone would choose to live in this particular town. As far as she was concerned she “was entirely convinced [she] would never live here”. However over time she became involved with the Caring Community and loved being part of it, had a sense of “this is home” and wanted to stay and be “committed” to the place and the Caring Community.

Not only the town was something she was initially not keen on, when she first heard her father mentioning the Caring Community in its early stages she responded with “utter disdain” telling him not to “be a weirdo!” She takes it all back now, describing it as “a cool idea”. In the beginning her participation in the group carried tension for her; the group was “super welcoming” and yet she always had in the back of her mind the resentment her mum held for the group and the anxiety her mother felt at being away from her father. She wanted to protect her mum and felt a strong loyalty to her and therefore felt like her dad “should go spend time with her [mum]”. She still sits with that tension; however this tension is counterbalanced by her belief in the value of the Caring Community. This was a subtle shift where she began to realise that she could see herself “hanging out with these people generally” and that she felt “a connection” with people there. Because she was living with her parents at this time, she acknowledged that her “entire motivation” for engaging with the weekly evening meals was “pure laziness”. She knew that dinner would be provided there, but that at home she would need to cook for herself. She finds it

amusing that laziness would be barrier for many people to going out, but that for her it is what got her there.

One aspect that Steph needed to get her head around before she could really commit to the group was the motivation behind the group. Initially she “couldn’t understand why” people were doing it, wondering if it wasn’t a bit “demeaning” and patronising. Once she began to get involved she remembers the feeling of “aaah I get the purpose now” and now sees the purpose of the Caring Community as “connecting with people, forming relationships and becoming a family”. “It’s nice to be able to say, here’s my place, here’s my people, here’s my family; and it’s nice for me to have people saying that about me”. Steph has come to the place where she feels that there would be no loss if she left the mainstream church, however “if I choose not to be part of [the Caring Community] there’s a huge loss to me and that is relationships”. She believes that relationships are allowed to flourish because of the values and culture of the Caring Community, and that the relationships are inhibited by the traditions and culture of the mainstream Church.

When she is at a gathering of the Caring Community she feels able to be herself, like she’s “not putting on a mask or a front”. She also relishes the fact that she doesn’t need to like *everyone* there, because that’s OK. She feels vulnerable there, in a way that is scary but good, describing it as “life-giving” and “very freeing”. The responses she has had to her vulnerability are ones of love and acceptance, “if I got a really awful reaction then I just wouldn’t go.” There is a sense of safety for Steph that comes from other participants’ commitment to the group, knowing that if they are there “they are invested in [her] life in some way”.

Steph acknowledges her decision to be a part of the Caring Community as “probably the biggest decision of my life” also noting that it was the “easiest and hardest decision to make”. It felt “natural” because that was where she “belonged” and that was the easy part. It was difficult because it meant turning away from the expected path amongst her friends; choosing not to be in the city, staying with friends, drinking and travelling. She acknowledges that at the time she made that choice, she wasn’t fully aware of the impact that would have on her friendships and has experienced much disappointment and heartache around them since. She also now feels a mental distance from her friends when they do get together, her “priorities about life and the way she sees the world” are now very different from most of them. This colours her feelings toward the Caring Community in a positive light as “I like who I am, I like that my priorities are with people, and wanting to do good in the broadest sense of the word”.

LILLY'S STORY: A STORY OF SAYING 'YES' TO LIFE

Lilly is a Pākehā woman in her 50's. She is a mother of 3 adult children and is married for the third time. Due to a current serious, potentially life-threatening, illness and a history of trauma she is not currently employed and is instead at home focussing on recuperating. She refers to her employment history as "eclectic" and "careering all over the place". Consistently though, her jobs have been "innovative work" with the purpose of having positive effects for others. Also important to her is the poet and musician within her and she has always felt frustrated at being unable to develop that into a career. Lilly was brought up in a Catholic home and as her experience differed from the teachings she was exposed to she began to explore her own personal theology. This was a lifelong journey that has taken her through disengaging from all churches, becoming interested in Eastern religions and practices, becoming a "born-again Christian" and finally moving away from Church again. She has always had "a very close relationship with Jesus, God, Holy Spirit" and her perception of God has changed as she has unearthed what matches her personal experience and what doesn't. Spirituality has always been a "top priority" for her, particularly after experiencing personal trauma. Even as she struggles with the daily things of life due to her current health, Lilly reads and listens to music; each day she sits down to sing three songs as that's all she "has the energy for".

Lilly tries to make "meaning of her illness" at the moment. Her body has "stopped functioning properly" and at times she cannot walk. She is "exhausted to the point of dysfunction" and her post-traumatic stress disorder (PTSD) has been "reactivated". She feels "stuck in a vicious cycle" and believes that there is a spiritual aspect to her struggles. The meaning she has found in her illness at this point is that it is her "job to surrender her will".

Health and well-being is something that Lilly has given much thought to. She describes being healthy and well as having "control over my own being" and "something like an inner peace, and an acceptance of [your] condition". She acknowledges that she is not in that place yet with regard to acceptance, she feels as though she is in an "in-between space"; not knowing if she will get better or she will die, "it's a horrible place, a place of great torment". She also sees wellbeing as "being connected to the community, a peaceful, joyful, acceptance of life". She sums this approach up as, "a yes to life, YES!" Lilly describes herself as someone who has "always been willing to take risks... not stupid risky behaviour... emotional risks". She views this as "putting [herself] forward to grow". She likes to be willing to explore things and

try them out, sometimes this results in positive experiences and other times dangerous ones. “You take risks, you get hurt, you learn how to defend yourself.”

Through her own experiences of violence and trauma, Lilly has learnt to find places to heal, “a lair in which to lick my wounds”, in order to be able to re-engage with life. Her story is of refusing to be knocked down permanently, time and time again she “runs back to my healing space” and re-emerges again.

Early discussion that Lilly had with kaitiaki of the Caring Community frustrated her “because they were so fluffy”. “It sounded like an experimental group where therapists were blurring the boundaries between themselves and clients.” She wasn’t sure if the idea was “crazy or not” but decided the only way she could know was to go along. She was “a little bit apprehensive” and had no intention to continue going, just wanted to see what it was since she “couldn’t get a clear answer out of anybody”. She recalls the stink of one man’s urine, the food was disgusting, and she felt hot. She continued to wonder why people whose intelligence and professional expertise she respected were doing this. She kept thinking “what the hell are they doing?” and decided to take another look. This was a time of Lilly’s life when she needed more in her life than work and her health had not allowed her to follow other avenues. Participating in the Caring Community was the first thing that came along that was actually manageable for her and she wanted friends, she had considered joining a church but every time she considered that she couldn’t manage the idea of “all the other stuff that comes with that”. For a while the group irritated her because she “doesn’t like undefined things” but decided that at the very least this was a good opportunity to bring her out of herself and to contribute to the community by providing delicious nutritious food for these people. She also recognised that being around other people who were suffering was probably good for her so she was not focussed on herself. Initially she felt like an observer, then began to take small steps getting to know others, and finally “gave up any further resistance and launched [herself] into the group”. This was a conscious decision. After more time she moved on to wanting to be part of shaping the group by being a part of kaitiaki, and has “ended up” caring about the people in the Caring Community. Lilly now “feels like part of the group”. Initially her intentions were to give to the community or “whatever else my ego thought it was doing”, now she sees it as being about both giving and receiving.

TRACEY AND AMELIA’S STORY: A STORY OF LETTING GO

Tracey is a Pākehā woman in her 50’s who is married to Amelia. This is her second marriage; her first marriage was to a man and she has two adult children from this relationship. She identified as bi-sexual

for a number of years, and once her first marriage ended came out “as a gay person”. She has lived in many places, with the longest being 2 years however she intends to stay settled in this town. When Tracey was a child she was slow to walk and meet other milestones and was eventually diagnosed with cerebral palsy. She struggled through school, with the physical and social challenges and also the medical interventions she required. These days people often don’t notice the disabilities she has until they see her doing “something fiddly”, and she is quite comfortable openly answering any enquiries these days, a change from earlier on. She has other health problems as well that affect her energy, pain, lymph nodes and breathing. Again she has undergone multiple surgeries in order to make life easier. She used to be scared to go out in public but having a permanent catheter inserted has helped her to overcome this anxiety making life “a lot easier”. Daily life is still a struggle for Tracey who spends much of her time in a wheelchair and so she says “I go through life the best I can and do everything I can do and if I can’t cope with something then I always ask for help”. Every morning she wakes up not knowing what state her body will be in and so “lives one day at a time”.

Amelia is also a Pākehā woman in her 50’s. This is Amelia’s third marriage; the other marriages were to men. Prior to meeting Tracey she had not been in any relationships with women, but now identifies as gay. She has two adult children from her first marriage which lasted 20 years. Her husband retrained during their marriage as a church minister and after a couple of changes of church and home their relationship fell apart. Her second marriage was not a happy one; he didn’t show her affection and after she had met Amelia she went to him and said it wasn’t working and that she didn’t think he loved her. He seemed happy that it was over and this reinforced her perspective.

Amelia loves caring for people, and has spent the last 20 years working as a community nurse and then caregiver, “it’s the best thing”. Tracey also wanted to train as a nurse but was turned down because of her disabilities. She has done various jobs over her life, her favourite being caring for the elderly, and is currently not working due to being unable to guarantee that she will be physically capable of work every day. She wishes she could go to work and contribute to their income and she is exploring what she might be able to do in the way of volunteer work.

Tracey was brought up going to church, Sunday School and Girls’ Brigade. After she “hit rock bottom for a while” she stopped going to church preferring to “go out and party” and get taken home by strangers. Once married with children, the only way to enrol the children into a Catholic school was by being baptised Catholic and so she was. Her husband stopped going to church, but she continued going and got

very involved. As the children grew and her marriage broke down she again stopped going and found herself “soul searching, wanting to find [her] faith again”. When she and Amelia moved to this town a friend invited her to an evening church and they went. They both found they didn’t get much out of this and then got introduced to the Caring Community and “it was good”, enjoying both the social and the sharing time.

Amelia was brought up in a home where at first only the males went to church, but by her teenage years she too was participating in the church youth group. This is where she met her first husband who went on to train as a minister. When she met Tracey she had drifted away from church but still held onto her faith and she had a strong sense that faith would be “immensely helpful” for Tracey. Amelia was really pleased when they moved to this town and Tracey was willing to re-engage with church and spirituality, “it was great, just great”.

Tracey and Amelia arrived in this town in quite tumultuous circumstances; they had been offered a place by a friend with a rent-to-buy situation. As they were driving to their new town with a second lot of belongings they were contacted by the police to say the vehicle they had borrowed from their friend had been reported stolen by him and that he was not allowing them back on the property. They ended up on the side of the street with all their belongings and pets and were taken in by a single mother of 3 children who had a sleep out they could use. This was an answer to their prayer and they had “a good feeling about the community of people, they were so helpful and so caring”. Eventually things “turned sour” for them at this home and they were asked to leave, but again they found temporary accommodation with someone until they moved into a flat of their own. This affirmed their belief in God and prayer.

The first time Tracey and Amelia went to the Caring Community they felt “a bit overwhelmed” but continued to go. They remember clearly the first time they went to a community Christmas breakfast they thought “WOW! What a spread!” and said they would be back. “The atmosphere was just wonderful” and they were “overwhelmed by the love there”. They knew there was love there by the people hugging them, the joy and laughter, and the happiness “when everything is like that you know there’s love around”. They have continued to participate regularly in the Caring Community gatherings; Amelia says this is because people have become friends, and then family. By hearing what people share she feels as though she gets a little bit closer to them and understands them better. Amelia recalls times when she has walked into a church and not felt welcome, even after long years of attendance. She feels as though she hasn’t fit in at those places, but that she sees herself “fitting in very comfortably” with the Caring Community,

taking on roles that she would “never ever dream of doing anywhere else”. Tracey has also found roles to take on that suit her personality like the MC role for the evening meals. She does find it hard sometimes to bring people back to the focus of the group and she does “get annoyed about people in the group for that, but [she] is learning now to just let it go”.

Tracey has found that she often learns from the experiences shared by others after the evening meal. In particular, she recalls getting insight into needing to “let things go”. She has a tendency to hold onto things and “let them fester”, and since one other woman shared about letting things go and giving them to God, she has been trying to tell God everything “and let him deal with it”. She noticed that even though the woman was sharing this for her own reasons, that she could reflect what was said and how it applied to her and learn from it. Practising this has certainly helped her to let things go. Amelia also finds “letting go” really important because as she works with people and their problems all day and the need to walk through the door into her home and not take that with her. She also tries to practice letting things go in their marriage, recently finding she was stewing about an issue she and Tracey had had before she went out and she went to step into the house the words that came to her mind were, “let it go”. This meant she could discuss it with Amelia in a more rational tone, and then to share it with the Caring Community and that was really good – “just letting it go”. Amelia feels as though saying “let it go” helps to not think about an issue all the time and make a more sound decision than if you let it fester. Letting things go hasn’t just been important mentally, when they entered into their marriage Amelia was in the habit of shopping to mask her pain and her house was filled with clutter. Tracey would keep reminding her that “hon, you don’t have to buy stuff anymore” and would make sure to give her gifts so she felt attended to.

LEROY’S STORY: A STORY OF AWARENESS

Leroy is a New Zealand Pākehā male, a retired white-collar professional who is married with 2 adult children who are also both participants of socially-inclusive Christian communities. Leroy has always seen himself as a dutiful Christian, helping others simply because that is the right thing to do. His faith was initially a ‘long-term inherited’ one, passed through many generations of family from within the same denomination of church. He feels saddened by the apparent lack of a fundamental belief in helping people in other Christians; something that earlier on in life he had assumed to be more common than he has experienced in reality. Leroy is ‘relatively unemotional’, tending to be task-orientated through life. This has served him well professionally, and he finds satisfaction in being able to help the Caring Community through practical tasks that others may not be able to, or not choose to do. Leroy’s focus has

continued to remain on helping others as he has deepened his commitment to the group, and doesn't feel as though the group has really helped him in a measureable way. He does see that by spending time with people outside his usual circles, his awareness of the daily struggles some people live with has been increased. This means that he has become increasingly aware of his own privilege and power, meaning that at times he feels constrained from participation in the group due to the apparent insignificance, or at least other-worldliness of his challenges and experiences. He sees this increased awareness as a positive as it means that he has increased empathy and understanding of the challenges that many people face, particularly as a result of a lack of access to disposable income and family or social supports.

Leroy has always taken a deliberate and future-focussed approach to making decisions; moving to a small town to balance professional expectations with raising a family and becoming engaged with environmental issues as a result of his keen interest in tramping. In more recent times Leroy has experienced disappointment with the church as an establishment and with fellow Christians' lack of compassion, awareness, or drive for justice. This resulted in him and his wife making a very significant choice to leave the denomination of church that his family has attended for generations. This was a difficult and challenging experience for him, and he has found himself in a not entirely familiar or comfortable church context. This period has also coincided with his decision to 'take more ownership' of the Caring Community and be increasingly active in his participation within it. As his participation in the community has deepened, so too has his understanding of issues such as health and well-being. Family experience and community participation has left him thinking that complete emotional and mental wellbeing is "not that common". Over the sharing times at community meals Leroy found many contributions were notable for their intensity and led him to wonder how people manage to live their lives with that degree of "problem, often problems". He has been reminded of how 'unruffled' his life has been and Leroy considers this insight to be a benefit of his participation in the community. He has been reminded that people face all sorts of issues every day that he has never had to face, or even most people he knows have not had to face. Despite having heard similar stories in his professional life, he has found the depth of emotional input that exists when being alongside people at community gatherings makes the experiences appear more vivid and often unresolvable than when he was listening to them in an outcome-focussed space. He enjoys the freedom of listening from a neutral space and not needing to deduce the 'truth' of the matter. This has been an "on the ground reminder" of what life is like for other people. What has surprised him about hearing these events is his personal discovery that, notwithstanding a person's somewhat 'reprehensible' role in their experience, he could like the people telling these stories.

Leroy doesn't really expect that the values of the community will change him very much, although he imagines that he will continue to become more sympathetic to others. The relaxed nature of the group times has also served as a reminder to him that Christian practices can be meaningfully carried out by people with no training or long connection with church, in a relatively unstructured way.

Another way that participating in the community group has increased Leroy's awareness is that he has become increasingly cognisant of the status, privilege and power that he has within the group. He is aware that he is older than most, Pākehā, male, highly educated, and wealthier than most others who are part of the community group. He recalls only occasionally having this heightened awareness of these things in other group settings. It is important to Leroy that people from all sectors of society participate in the group and he thinks that something would be lost from the group experience if any sector was missing, but in saying that he is still aware that he belongs to a privileged sector. This consciousness has possibly inhibited his participation. He has since wondered whether he hasn't tried hard enough to have his experiences understood and now wishes he had taken the opportunity to share more.

Many times Leroy has helped other community participants with shifting house. He found these experiences a mix of utter chaos and fun. It was also challenging to see the differences between people, himself included, and what they value. Leroy was surprised by the way other people are living, in amongst incredible amounts of clutter, or other times with very few items at all. He considers this reminder of how other people are living to be a positive thing, that it's important for him to know that. He was struck by the way that poverty impacts people in ways he hadn't really thought about previously. Limited funds for food or housing was obvious, it was the way that other people were unable to do 'routine things' like getting cars or household items fixed, accessing medical and dental treatment, and disposing of rubbish that he became aware of. He also expressed an insight into the difficulty that exists in governmental services that he and many others take for granted; now regarding Work and Income [WINZ] as "a bit closer to the enemy" that he previously had, based on how rejectful it can be. He came to this opinion after seeing community participants going to WINZ to seek assistance and were treated "abruptly, almost rudely" and he guesses that often people do not receive what they are entitled to. This has again made him acutely aware of the privileged financial position he lives in and reflected that at holiday times it's sad that when half the country drives around the country to visit others and travel, the other half has no means to visit a friend 30 minutes away.

STORIES OF BELONGING

FAMILY

Leroy is a man who spends a lot of time with his family. When he was working he structured his employment around his family, and now that he is retired he spends a lot of time with his grandchildren, enjoys going away with his wife, and being involved in the pursuits of his daughters. His faith is personal, and also inherited from a long Christian heritage. Leroy and his wife primarily became involved in the Caring Community to support their daughter, son-in-law and grandchildren with their involvement in it. He did not necessarily have any intention of “belonging” in his own right. He can’t recall any other reasons why he would have sought the group out, although it did provide him with an opportunity to be involved with something as he was not finding that in his church at the time. Although his initial motivation to go was to support his daughter, he is also aware that he and his wife held off from going for a while. It was their thinking that their daughter’s world and theirs crossed over in many ways already and they did not want to impinge on “her space”. His sense of commitment has grown beyond his family over the time he has been going, acknowledging that in a deeper way than in previous churches and groups, when you go to the Caring Community “you are committing more to fellow people that go to it, and wanting to be part of their lives and them part of yours.” For a long time he described the Caring Community to others as, “the group that my daughter and husband run” but has come to realise that he can say it’s “my group”.

Over more recent years he has supported family members who have struggled with emotional and mental health concerns including the daughter who is also part of the Caring Community. Leroy had found that being part of the Caring Community has helped serve as a reminder of what life is like for other people including her and her family. He acknowledges that his daughter has health issues and “regards it [the community] as a fairly important thing” and he finds it good to see and recognise that.

WHĀNAU

Tīpene is a “very family orientated” man, always there for family if they are “in trouble.” He is very protective of his many nephews and takes pride in being a good example for them. Having grown up between the homes of various foster families, Tīpene now commits sincerely to family in all its forms. He considers the Caring Community family, “I actually describe it as being a whānau” and that “you can go as you are.” When describing the Caring Community Tīpene has heard some people focussing on a meal “for if you are hungry”, however he feels as though “that’s only a small minute part of it”, most importantly it’s whānau. To be a part of that whānau “boosts [his] ego”, “you have your ups and downs;

you have your rarurarus... however you can still come back together as one.” These ups and downs come from something very important to Tipene and that is unity and diversity, “we can be in unity however we can be diverse. That’s what I like about [the Caring Community] is we are diverse, and we do have that unity... that concern for each other.” That unity gives him a sense of “satisfaction”. “Getting my needs met, however meeting other people’s needs. Give and take. And that’s what a family is, it is give and take, they learn to compromise with each other.”

LOVE

Tracey and Amelia arrived in this town in a vulnerable position; all their possessions and pets, with no money and nowhere to stay. Due to the kindness of a stranger they soon had a place to stay and recall having “a lovely feeling about the people of [this town], they were so helpful and caring.” After a few months of living here they began attending a shared meal of the Caring Community. They remember particularly strongly sharing breakfast on Christmas morning, “the atmosphere was just wonderful”, “it was overwhelming for me to come in and see so many different people and how wonderful the meal was, it was neat.” “It was a WOW factor!” Amelia recalls feeling “overwhelmed by the love that was there”, noting people hugging each other, joy and laughter. They have continued to participate in the Caring Community because of the “fellowship of friends that have become family.” It is due to this fellowship that they feel welcome, “I feel really comfortable... if I ever need anything all I’ve got to do is get on the end of my cell phone and ask and I’ll get the help, in whatever way necessary.” Tracey describes the community as “very warm and welcoming”, “I feel the love that’s in there amongst all the [community] people”. One particular practical time that they both experienced this love was when another participant asked whether they would have her car, “It was incredible.” “She said she wanted it to go to people who deserved it and really required one. I don’t think I’m deserving, but she obviously thought I was.” Tracey has experienced people noticing her needs, one other community participant weekly notices her arriving and goes to open the double door so her wheelchair can fit through. These kind of actions have led to Amelia feeling better able to participate knowing that people other than her are sensitive to her wife’s needs. They have both appreciated “the love and care” that people have shown for them, checking in if one of them has been away from a gathering. Prior to being given the car, other participants were “concerned that we couldn’t get there in the winter” and one man picked them up every week while it was cold and dark, “to have that made us feel loved and wanted and secure.” Tracey imagines the Caring Community as a tree, “we are the branches reaching out and protecting [the community] and whoever goes in and showing them love in some way; opening up the doors for them, having a free meal with a bit

of social time afterwards... and as we get stronger as a group the branches spread out more into the community and try to bring more people in to share that love, that the tree of life gives us.”

“The [Caring Community], there’s not friends in it, but they’re our family in Christ, we can go there for support, for love, for friendship, it’s the people in it that to me are our friends but it’s an extension of our family in Christ.”

SUMMARY

Participants of the Caring Community each described the subjective sense of belonging differently. The relationships that pre-existed coming to the group, and the new relationships built there were key factors in the way that the participants experienced their belonging to the Caring Community. Participants were often the most expressive when describing the connections that they have with the Caring Community, and not only the individuals within it, but the group as a whole.

STORIES OF IDENTITY

PROFESSIONAL AND PERSONAL

Lilly has spent her life doing jobs “mainly in the area of wanting to help people”. At the time that she was introduced to the idea of the Caring Community she was working in a very “people orientated” job and reached the point where she had “absolutely had enough”. She wanted to be able to choose who she spent time with, not being expected to listen to everybody, always being open and empathetic. The idea of going from a professional space with people into a personal space with those same people “put [her] off for some time”- “there is no way I would ever want to go into anything sociable with them”. Despite these feelings she had a need for something in her life that wasn’t work and “it was easy to join the [Caring Community]”. Initially Lilly went along “with a professional hat” and then “bit by bit” she “shed that professional face” and became herself. She feels as though this was facilitated on a personal level, by relationships that she had with two kaitiaki whom she had met in a professional context but the relationships were growing into something else. After a while she realised that “it didn’t matter if they knew bits about [her].” She maintained some reserve but compares that to the majority of her relationships where she holds somethings back. Lilly is no longer employed in that capacity and that has also meant that she no longer feels that she has a professional reputation to protect and can just be herself with the people there. She is also very clear that she is no longer going to help the people and observe, but is a part of the community, giving and receiving. In the past Lilly had separated her “needy, wounded

self” from her work in order to meet the job requirement, “you can’t have a sick person at work”. She feels like she can see the “sick person” she has become, a part of her that has been “largely invisible” for a long time. She feels more balanced now, she can “open herself to receive from others”.

COMMUNITY AND INDIVIDUAL

Steph’s definition of health and wellbeing is that “it’s definitely a collective thing.” It involves “physical health, spiritual health, mental health and relationships.” “If you’re not happy you’re not going to be motivated to get well in any other sense of the word... that’s with your friendships, your relationships or whatever else.” She is aware of issues community-wide that affect the health of the town, “huge issues with poverty, violence and health. Sometimes it just feels like the town’s depressed and other times it feels like a joyful place to be... people have had trauma in their life and that’s just continuing on affecting them.” “I think having a lot of people who... aren’t happy with their lives and are going through difficulties does impact other people, coz other people can feel that even though they might help or they don’t care. “

When she first attended Caring Community gatherings “it was kind of awkward” she didn’t know anyone and saw herself being there because she was the daughter of a kaitiaki. She recalls a strong memory from early on in the community garden with me (the researcher). “I was sitting there with my feet digging in the dirt, pulling out potatoes and chatting... there was a subtle shift, being like, actually, I can really see myself hanging out with these people just generally.” This is the purpose she now sees in the Caring Community; developing relationships and becoming family.

Steph has been a part of communities in the past with similarities and differences to this Caring Community. Her church community is not one she really feels a part of:

I feel a bit like an outsider forcing myself in, and kind of forcing people to interact with me... Her university community had many strong relationships, however if I did something out of line, that was it, I got told off and threatened to be kicked out ... I think this is why I love being part of [the Caring Community] so much, is that if I do something that people don’t like I’m not gonna be kicked out. People will just be like ‘hey that’s not quite how we do it, let me help you’ and be shown love and care rather than disdain... I kind of feel like [the Caring Community] is totally different to anything I’ve been a part of, and I think that’s why I love it so much, because everything else I’ve been a part of I haven’t really felt a part of.

SUMMARY

As people began to consider themselves a part of the Caring Community, this resulted in them defining themselves and their relationship with the group. For some participants this involved letting go of something that was previously a part of their identity, and for others it meant taking on board a new

aspect to their identity. These decisions were related to individuals defining themselves, and also defining their identity in relation to the group.

STORIES OF SAFETY

VULNERABILITY

Although Steph hates to paint this town in a negative light, “there are a lot of people with mental health, severe mental health issues, and probably because of trauma and that means they can’t work.” She believes that means that there is either “tension in the community that doesn’t necessarily bring happiness, or, there’s tension that means people are actually connecting and talking about it and relating.” Steph thinks that the town’s vulnerability can lead to positive outcomes “hopefully that’s the stuff that starts to build up more and more in the community.”

Steph finds she often avoids vulnerable conversations, for instance discussing her spiritual beliefs “I haven’t really talked about that much and I’m a little bit scared to talk with dad about that, and mum.”

However, while participating in the Caring Community Steph has discovered value in vulnerability:

I guess there’s that vulnerability that’s scary and I’m not gonna say I like it... but I feel like it’s really... life giving. I feel able to be myself at [the Caring Community]... I don’t have to wear my professional hat... When I am vulnerable it’s really affirming for me, and it’s also really scary because I’m showing the innermost workings of me... and that’s quite scary, but also when I do it’s always been a really positive reaction. I guess that’s why I do it.

To Steph being vulnerable means being honest with people about how she is feeling and thinking and how she is being affected by what’s going on in life. She describes the positives of being vulnerable in the context of the Caring Community as feeling like “I’m being a genuine part of me, or whole. I don’t feel like I have to try to uphold some sort of standard. I can just be me. It’s not something I’ve really done outside of [the Caring Community].”

TRUST

When Tracey and Amelia arrived in this town and were taken in by a single mother and her 3 children they considered it “an answer to prayer.” It meant they had a home and they also felt that “our presence was needed in that family... to help them through the situation they were going through.” They helped out the mother and her children and “the kids trusted us enough to talk to us if they couldn’t talk to mum.” When this situation fell through, “God answered our prayer again and had put a roof over our heads.”

Amelia described how the sharing process in the Caring Community evening meal gatherings has helped her to trust that she can ask for help,

because for someone to share what they've gone through and what they've got out of it, you're actually getting closer to that person and understanding them a little bit more. That gives us confidence to be able to ask if they can do something for us.

Tracey and Amelia feel that they have gotten to know people well enough to share their problems and needs,

If there's something happening [in your life] then you know that you can share it in the group... by sharing your struggle it means that each and every one of the people that are there know your circumstances and it's a privilege to be a part of the group.

These relationships also provide the space for Tracey to participate, "I see myself fitting in very comfortably there and I'm prepared to even be MC which is something I would probably never ever dream of doing anywhere else."

Amelia appreciates being trusted and recalled times when she has experienced others trusting her; when she was working and being asked to take out a valuable car, being asked by another community participant for help with their household chores, and being asked to say grace at a Caring Community meal. "It's sort of like he's come to me, he knows my ability otherwise he wouldn't have asked." Amelia feels as though she has a deep understanding of the trust required to share your problems with others because of her work as a caregiver. Tracey feels similarly "I offered to take the towels on Sunday because I can be trusted to do that... I can be trusted to be MC." Dealing with setbacks with their living situation and also with Tracey's health means that they have learnt to trust in God, "my trust in God gave me the will to come up and to be able to calm the waters."

They both describe feeling safe at the Caring Community gatherings, "I think it's just the love of the place; the peacefulness, there's no discrimination. I feel safe when I go there cause I know God's protecting me in that particular area. It's just a time to let go and share amongst other people."

RESPONSIBLE RISKINESS

Lilly says she had always been willing to "take risks" so long as the potential consequences are ones she is willing to accept. She has become particularly good at protecting herself and making sure that she accesses what she needs to in order to feel safe. After a very significant traumatic life event Lilly needed a safe place to recover. Part of her didn't want to return to the place she was from; she was known there, her children were known there and she wanted to protect them from the comments of others. She knew

though, that her support was in that place and so she did return despite her fears. When she finally moved away from that place for good it was when she was emotionally able and ready to do so.

Every time the theology of a group differed from Lilly's experience she would search some more. This process wasn't without difficulty for her, but spirituality has always been a top priority for her. She has described herself as always having had a "heart for the underdog", always wanting to include outsiders since she was a child. Because of this she felt as though it was consistent with her nature to be a part of the Caring Community. The knowledge that there were mental health professionals participating in the group helped to provide Lilly with a degree of safety because although she chose to be there, her previous life experience means that she is uneasy around unpredictable people. Lilly wasn't sure whether the idea of the Caring Community was crazy or not and decided the only way to really know was to go along and see. She knew a couple of people involved and respected them which gave her a small measure of confidence. As she chose to be involved her motivation was initially to be charitable to others, now she has become more vulnerable, being willing to open herself up to receive from others.

SUMMARY

Safety was a paramount concern for many of the participants, particularly those who considered themselves to have been harmed by others in the past. Safety was established in a number of ways and did not refer just to a lack of threats to physical harm, but also cultural, spiritual and emotional safety.

STORIES OF PARTICIPATION

HELPING AND CONTRIBUTING

Leroy has always "tried to be moderately helpful" to other people, spending much of his time now that he is retired helping out with the care of grandchildren and with charitable and organisational activities. He believes that because this town has a moderate climate and relatively cheap accommodation it has built up a large population of people who, due to age, illness, or other reasons, cannot work. Because of this he suspects that there is a large number of people who potentially need help and that there probably is not enough help available for accessing locally. Leroy has seen participation in the Caring Community as a way to help others locally, his daughter and grandchildren, and others who have become known to him or even friends. He used to describe the group in relationship to his daughter, recently though he is actively trying to take more ownership of that, changing the way he refers to group and viewing himself as a part of the group rather than a person facilitating other people's participation in the group.

The times when Leroy finds participating in the Caring Community difficult is when he listens to people's intense stories of difficulty and he cannot see any way that the group can be helpful, other than to listen. He doesn't have any expectations that other participants will seek him out to talk to him about "matters of importance" and so finds that he tends to help people with physical tasks like shifting house. He is also concerned that the Caring Community not become too focussed on itself and continue take up ways of "serving others" outside of the group.

Being helpful has long been a theme in Leroy's life; when he was growing up, helpfulness was valued in his family and he took it for granted for a long time that all Christians placed the same importance on helping, "at one level duty says do it". He acknowledges that people get tired of "doing good or helping" but doesn't feel as though that has anything to do with whether you continue to do so or not. It appears to Leroy that mutual help is one of the primary reasons for the existence of the Caring Community.

STRUCTURE

Jonathan was keen to engage with the Caring Community when he discovered it as he saw that it "filled a clear social need, could help people, and not be judgemental, purposefully non-judgemental." He contrasts purposeful non-judgementalism "I've never seen [the kaitiaki] making a judgement to other people, rather, 'if you do it this way you'd get better results'", with non-purposeful non-judgementalism "some people don't have any opinion, they just go and do things." The Caring Community was different from other groups he has been a part of, "the leadership is completely different, it is consensus driven by a management committee who is under supervision from the kaitiaki, and then under general church observation." Jonathan believes that the multiple levels of engagement and involvement in the Caring Community, "some of which are not directly involved in the organisation and the running of the structure", have meant that the community has avoided the abuse that some close-knit communities have. He compared it to another group he has been a participant of:

One group does things for people, with very little return... and in the [Caring Community] they are giving guidance to, and helping people do things. One of the main things too is that at the [Caring Community] we tend to bring food and share, at the other food is provided... it's a major difference in the attitude of the people.

Jonathan reflected on the lack of expectation that people who come to community gatherings stay to help, "that's one good thing and one bad thing simultaneously." He also notes though "we ask people to help out at [the other group he attends] but it hasn't made that much of a difference."

"A lot of people are scared of formal things" and because of this Jonathan thinks the Caring Community structure is "good":

You know what you'd like to do, you know how you want it to be done, you know why, your own faith, and you're a little laissez-faire to give others room to come and go and to grow, and that's important. Coz you won't get too many people turning up if you set down hard and fast rules, do it this way, coz they won't... You go on turning up, doing what needs to be done, and helping out as needs be, while giving others a place to actually grow up for themselves.

LEADERSHIP

Tīpene has been involved in church ministry for around 30 years. He has been involved with many types of church, many of which had a very "hierarchical" structure and he has found the structure of this Caring Community a challenge. He says he has been in a lot of churches where the pastor is the "big cheese" and if you don't obey them then "you're out". He used to be afraid of leaders because of this but has now got to the point where he thinks "everybody has their point of view." Since he has been a part of the Caring Community, a lot of his "theories and theologies have changed" and "sort of been turned upside down and around." This has been difficult for him. Tīpene believes that people have their strengths and that there should be a clear leadership structure. His participation in the Caring Community has resulted in a more flexible view of what a "clear leadership structure" looks like. He also says that now he thinks that "the leadership shouldn't step in unless they are needed to." "I had to fight it myself coz I'm so used to being up the front... I have to bite my pride and step back." Tīpene's own personal experience of this in the Caring Community was being asked by a kaitiaki "what can we do for you?" This was a contrast to his previous experience of leadership telling him how to fix his problems.

Tīpene describes the Caring Community as "very unique" in the way that the leadership structure is one where everybody takes part. Because of this, he sees a wide-ranging group of people and voices represented; noting both diversity and unity in the group. Growing up he saw a lot of negative relationships between leaders, "you would see them arguing all the time". He also became a minister in a context where the attitude of his congregants was that he needed to do no wrong, and that if he ever needed help there was something wrong with him. In contrast to these attitudes he describes seeing the kaitiaki "down" and seeing the kaitiaki "up" and "we see you be yourselves".

In a different context where Tīpene is in a leadership role he now often asks himself "what would the kaitiaki do here?" as a way to try to get his head around a different way of being with people. The Caring Community has influenced the way he is training others too, Tīpene says he now teaches people to know

what they can “handle” and how to refer to experts, he is practising putting more trust in people and letting go of control.

SUMMARY

Each participant of the study has told a different story of how they went from spectator to participant in the Caring Community. Some consciously chose to become a participant, and others described finding themselves there before they thought about it. For each participant, it appears that increased participation has coincided with an increased sense of belonging.

CHAPTER FIVE: FINISHING THE STORY, DISCUSSION AND

FINDINGS

INTRODUCTION

A self without a story contracts into the thinness of its personal pronoun (Crites, 1986, p. 179).

The stories of seven participants of the Caring Community have been collected and presented. Themes have been identified as each individual story has been carefully read separately and in relation to the other stories. In this chapter these identified themes are discussed.

FINDINGS

As discussed in chapter three, I categorised my lines of inquiry into three groups during the structured conversations I had with participants. This was in order to focus my thoughts around how participants came to interact with the Caring Community initially, how it was early on, and why they have continued to participate. To be consistent with the approach to the structured conversations, the findings of this research have been categorised around the same three stages, these have been titled 'Coming', 'Being', and 'Staying'. There are some findings that sat outside of this process and have been included under the sub-heading 'additional findings'.

COMING

The initial period of first coming to the Caring Community was often characterised by feelings of frustration or awkwardness. The values were new and differed from people's personal values; the structure both of the mechanisms of the group and also of the low hierarchy was different and challenging; the people were unknown and unpredictable. Due to the difference between participants' previous experiences and their initial encounters with the Caring Community, participants found themselves confused by what exactly the group was. A lack of formal induction process, or shift from 'outsider' to 'insider' meant that the process of comprehending the group and its kaupapa varied in duration and value for different participants.

All participants' stories included ways in which their experience of being excluded from other groups or places played a role in coming along to the Caring Community initially. An example of this is illustrated by Tracey's experience:

I went up and was getting Amelia and myself a cup of coffee and they said something about my 'friend', or was that my carer or something, and I said 'no no that's my wife', and they were taken back, they couldn't accept that I was gay and said 'that's not your wife'.

A positive aspect of their experience within the Caring Community often involved the proactive involvement of an 'excluded' aspect of themselves.

It's been a very different experience... When we went up to him and introduced ourselves and he said, 'oh its lovely to have you. Are you married?' and we said, 'yes we are' and he said. 'oh lovely' and he just took it in his stride.

For instance, the inclusion of the taha Māori of Tīpene was significant, as was the inclusion of physical disability, or homosexuality, or questioning intellect. This is in contrast to the cultural norm of not calling attention to difference, or 'not seeing' aspects of people like colour or physical disability. This positivity expressed by people around early experiences of the identification and inclusion of their difference, and the universality of prior experience of exclusion suggests that there may be value in consciously identifying new people's prior experiences of exclusion early on so that they can be proactively included in these ways.

We see from participants' accounts of their own identities and experiences that it is possible to have one group attract a varied range of people. It was also apparent that people's journeys up to the point of first encountering the Caring Community are very diverse. The participants' stories reflected very different social locations, upbringings, expressions of faith, education etc. and their motivations for initially going along were wide ranging.

As I heard more about the participants' early experiences of the Caring Community, I was surprised how strongly the theme of feeling safe came through. It emerged that a sense of safety or trust was required for many of the participants to embark on a journey of participation and subsequent belonging. Yuval-Davis (2006) described this need as follows, "a sense of belonging is as much about "feeling safe" as it is about emotional connection" (p. 198). This made sense as I discovered that safety played a part in all the participants' stories about the Caring Community. The role and purpose of safety changed depending on the individual. Some participant stories focussed on attending the Caring Community in the hope that they would find safety there, others articulated a specific need to feel safe within the community, and others discovered safety there without specifically seeking it. Participants who described the Caring

Community as a 'safe space' confirm what the literature says about how a 'safe space' is not defined by the absence of discomfort. They described sensory displeasure in the smells, crowdedness, and poor food; they described not liking all the people there; they described some other Caring Community participants as unpredictable and even unsafe. Despite these descriptions the Caring Community was still considered by participants to be a 'safe space'. In the Caring Community participants found a place where they could safely express their sexuality, ethnicity, spirituality, opinions, and faith, and develop mutual relationships with others. The presence of mental health professionals, even though they are not there in a professional capacity, and the clear expectations around values and boundaries served to act as a container of safety within which the other things occurred. "I don't like being around people who could go completely nuts, for obvious reasons... but to know that there were professionals in the place that could actually deal with that situation made it safer."

BEING

'Invitation' played an important role in the stories of participants. First and foremost, all participants were only aware of the Caring Community because they had been invited along by someone they had a pre-existing relationship with. Secondly, participants expressed the significance of being invited to carry out roles or tasks within the group. It surprised me how much significance the participants attributed to invitations to carry out what were often perceivably small roles. However the implication was that people would not ask others to do these things if they didn't trust them, believe in their abilities, or have respect for their particular skill-set.

The book was sitting on the table, it was just sitting there, and noone wanted to take up the opportunity to be the MC, and I said I'd do it. And people said, 'oo good! You're really good at doing MC-ing'. And I thought 'wow, ok' and I gladly did it because I thought, I could be trusted to be MC.

These moments of invitation often served to facilitate people from the space of attendee and into the space of participant. When people being invited to carry out roles is viewed through the lens of their previous experiences of exclusion it helps to explain the significance for participants. For people who have previously been excluded from groups, to be allowed to attend is an improvement, whereas to be actively welcomed and included in the fabric of the group is considerably more beneficial.

There is a paradox inherent in the fact that the very frustration and awkwardness that characterised the 'coming' stage became something that kept people 'being' within the Caring Community. At times it was

in spite of these feelings, but other times participants' explicitly stated that they "didn't get it" and wanted to keep coming in order to comprehend the group, or define for themselves what it was about.

The food was disgusting and everyone looked like a bunch of loonies to me, and so my first impressions were not something that endeared the group to me at all... I kept thinking what the hell are they doing? Ok I'm going to give it another look.

The experience of being a part of a group with a commitment to consensus decision making, rather than decision making at the top levels of hierarchy, was challenging for some participants and yet they described valuing being a part of a new way of doing things. The structured conversations did not focus on this paradox and as such further conversations would need to be had to build a hypothesis about why an aspect of the Caring Community that was frustrating and challenging played a role in people's continued engagement.

The clear documentation of culture and practice was a valuable contributor to participants' sense of safety and continued involvement with the Caring Community. One specific aspect of this was the inclusive language used in the booklet; Te reo Māori, gender inclusive pronouns, and the use of a modern translation of the Bible. The significance of this booklet for participants surprised me. This document is read from weekly in one of the Caring Community gatherings and describes the values of the group, the Biblical basis for the selection of said values, and articulates how those values may be expressed or experienced within the group gatherings. Having a document that people can refer to and does not rely on the accurate recollection of one individual to another creates a collective understanding around the expectations for behaviour and the values that underpin those expectations. In a context where people are not always predictable, a consistent and pre-understood way that the group responds is helpful in creating a 'safe space'.

Having a variety of roles that people can take on within Caring Community gatherings helped participants to establish themselves and their own sense of belonging to the group. The diversity of the roles and the flexibility around time to prepare, or not, provides people with differing skills and personality types the opportunity to find something they want to do, in their own time and at their own pace.

I know I do [belong to the Caring Community]... because I'm getting involved with helping more, ok for offering to do grace, prayers, mc, when they ask for people at the end of a night, to help with dishes, taking rags home... I wouldn't have done anything to start off with, but once I

started feeling more at home, more relaxed, and thinking well, no one else is putting their hand up, she did it last week; maybe I'll put my hand up.

Participants in this research expressed filling some roles with ease, other roles that they would probably never do, and still more roles that they were feeling more inclined to do as a result of an increased sense of belonging within the Caring Community. The looseness with which the community as a whole regard commitment, taking into account fluctuations in individual capacity, helps people to feel safe to try roles out and remain in control of the level of their participation. Generosity is a value that is encouraged by the Caring Community, and all the participants in this study appear to have found helping others as a way to meaningfully participate in the community. As I discussed earlier in chapter two, studies show that participation contributes to a sense of belonging (Anant, 1967; Granerud & Severinsson, 2006; Jetten et al., 2012; Putnam, 2001). None of the participants articulated this specifically, however what was evident from their stories was that there was a correlation between increased participation and increased sense of belonging. An article that helped elucidate the participants thoughts around safe levels of engagement and participation was the Pōwhiri Poutama approach to therapy (Drury, 2007). The model uses the process of a pōwhiri to explain the different places people find themselves in terms of their readiness and willingness to engage and participate. People's early family experiences appear to be related to their participation in the Caring Community in one way or another. For some participants, this meant their early experiences of hospitality in the home and a focus on helping others was something they actively continued into adulthood. For other participants, the Caring Community was an opportunity for them to become a part of a secure and loving family, a contrast to their early experiences. As with safety, family was a part of every participant's story of engagement with the Caring Community. Some participants didn't have positive experiences of biological or caregiving family, and they sought a family of choice in the community; finding that belonging and support was the "natural counterpart to social isolation and loneliness" (Tomaka, Thompson, & Palacios, 2006). Other participants had really positive, strong, loving experience of biological family, and were very happy to extend that experience to a broader definition of family, and also to offer that to others.

For participants who had been hurt by groups and social structures in the past experiencing safety within the Caring Community was aided by transparency. Ongoing clarity around power structures, decision making processes, and values was necessary for continued engagement with the group. This was particularly evident in the experiences of the participants who had had interpersonal difficulties in the group, such as a complaint laid against them. A sense of dignity and autonomy was maintained by the

participant knowing what processes were being utilised and being directly communicated with. Not all of the pain from the experiences was removed, but it meant that they were able to continue to belong, and participate in the Caring Community in an appropriate way. The resulting change in the pattern for people who had been excluded from groups before was significant; had they not been involved in the transparent processes, then they would have been excluded again, repeating prior cycles. This process showed that marginalised people and people with mental health struggles can have difficult conversations in a context where they feel valued and safe. The way that transparent communication also included openly, naturally, discussing problems and struggles in people's lives, such as mental health issues or financial difficulties, led to a normalising of these issues without having them as the focus of the group, like they would be in a treatment group. Participants perceived this as a holistic perspective of identity, where problems are a normal part of life, but are not the source of identity.

STAYING

When participants accepted the invitations to participate in various roles within the Caring Community, this developed into belonging and a sense of ownership. They began to have ideas about how roles could be altered and it aided in the shift of perspective from "a group I go to" to "my group". Fisher (2012) found that the key to gaining the trust of marginalised people was in making them feel valued. "Group leaders began by inviting [participants] to share their experiences and asking them what their needs were and how the church and community at large could respond to meet those needs" (p. 3). Tipene described exactly this happening with him in the Caring Community and how it took him off guard, but ultimately how powerfully respectful it was for him to be asked his own opinion on his situation, and how others could respond.

Participants of the research mentioned learning various new skills and values. They also described taking these learnings from the Caring Community into other areas of their life. These also included shifts in their attitudes towards themselves and others that they found were impacting the way they communicated with people from outside of the group.

The way that the diverse participants of the Caring Community told their stories of the various people who they are a part of the community with shows that a varied range of people can come together as a group and have genuine relationships with one another. The value of reciprocal relationships also emerged in the participants' stories. Two of the Caring Community kaitiaki who are also counsellors have reported their desire that counselling be specifically used as a tool in periods of need, and that belonging

in community becomes a lifestyle that continuously facilitates health and transformation (personal communication).

Definitely helps me when I'm feeling anxious or really low and I just have someone there to be like, blaah, get it all out, and work through that and get into a healthier space. And also when I'm feeling, having tensions or conflicts with members of my family and get away and have someone to listen and actually give some perspective on that.

This sentiment is also articulated by Lasch (as cited in Crossley, 2000):

Therapy is just a means of adjusting dissatisfied individuals to a flawed social environment; a narrow substitute for the deeper range of involvement available in pre-modern settings. Therapy therefore becomes a form of indulgence promoting narcissistic withdrawal, dependence and passivity, and a reluctance to address the inescapable moral and existential dimensions of life's problems. (p. 161).

Mutuality within relationships formed within the Caring Community was evident in many ways in the participant narratives. Leroy had a deep sense of new understanding of life's struggles for many people around him. Catholic Workers Movement activist from the 1930's Dorothy Day said, "We need always to be thinking as writing about [poverty], for if we are not among its victims, its realities fades from us. We must talk about poverty because people insulated by their own comfort lose sight of it (as cited in Davis & Patel, 2009)." Leroy had never lost sight of poverty and injustice, due to his internal commitment to justice and his professional contact with a wide range of people; however his lack of personal proximity to these people prevented him from developing a real empathy for their situations and this has come about through egalitarian interactions within the Caring Community. Through time and engagement with one another "participants come to see the group as 'us' not 'them' and this emergent sense of 'us-ness' lies at the heart of their curative experience" (Jetten et al., 2012, p. 332). Fisher (2012) found in her study on transforming communities that for many people the beginning stages of new awareness of other people's struggles led them to feel uncomfortable talking about their own struggles and lives as they sensed the inequality and discrimination inherent in their situations. Leroy described feeling similarly, although has reflected that with hindsight he thinks there is still value in sharing his stories for people to connect with him. Although participants' stories of how they first came to the Caring Community were varied, as they stayed and began to consider themselves a part of the community their stories of belonging and participation became very similar. These stories focussed around being a giver of help and a recipient of help; learning from others and teaching others.

Participants described the Caring Community as a space where they could congruently express their spirituality practically. For some this came as a surprise; their previous experience of institutional religion, i.e. mainstream church, was one where lived spirituality was a theory not a practice. Others thought that they were the only ones who held a particular view of theology or spirituality, and after being able to express their views in a theologically 'safe space' discovered that they were not alone. Sometimes when listening to the stories of the participants their references to faith or spirituality seemed hidden. As I reread the stories I realised that this was because spirituality was considered inherent throughout these stories; all had aspects of their individual's faith interwoven throughout. This approach to faith fits with the Māori concept of wairuatanga - the interweaving of the spiritual realm and the everyday. The Caring Community has provided space for participants to find beliefs that they are comfortable taking on, and finding freedom in not being told what to believe. For each of the participants, faith was an integral part of themselves, not a feeling that could be turned on or off depending on how they felt that day; it was an intrinsic part of their identity even if they were unable to articulate the specifics. The Caring Community has in each instance created space for each individual representation of spirituality to be valid and contribute to the spirituality of the group as a whole. This is in contrast to the institutional church that Johnson (2004) describes as, "ultimately about maintaining itself" (p. 33), stating that in order to achieve the survival of the institution individuals are expected to remain within the status quo.

This research presents the complicated stories of often marginalised people. They told their stories from the perspective of individuals who experienced themselves as having agency in their lives. Life had struggles, life had good moments and they were a part of these; this is in contrast to stories often told by people of life happening to them. There is no way of knowing from this research whether this is a function of the community, or of the individuals. It is unexpected, though, to have a group of people with traumatic stories who see themselves as active players in their stories (B.A. Van der Kolk, 2014; Bessel A Van der Kolk & Van der Hart, 1995).

ADDITIONAL FINDINGS

The initial stages of engagement often held feelings of confusion, frustration, and apprehension. Relationships appear to have been the key to mitigating these feelings of apprehension, with all of the study participants reporting that the connections they already had with people there, or new relationships they formed, being pivotal in their decision to go again.

As people described what in their lives they each considered had led them to being who they are, I heard many stories that I had not heard before. These stories helped me to get a bit more of a glimpse into what

had drawn people to the Caring Community in the beginning. I gained an understanding of how Tracey and Amelia's relationship with each other, and also with the Caring Community, is a new experience of genuine love and depth of relationship. In light of this, I was pleased that I trusted the process and didn't end up forcing them into another place of separateness by insisting on having structured conversations separately with each of them. The way that they noted specifically the lack of "spiritual togetherness" in Amelia's previous marriage also struck me as it seemed that they pointing out something uncommon to me.

Many people who are part of the Caring Community have been required time and again to tell their stories in a way that they don't maintain tino rangatiratanga, or autonomy, over. This happens every time a health-care worker changes and time restraints mean they haven't read the case notes, or they have a 10 minute appointment at WINZ to justify why they have no money for food this week, or why they are unable to work, every time they are instructed to tell their story in way that is for the benefit of a professional rather than for themselves and it is heard with an absence of empathy. People's stories are personal and valuable and yet many people experience structural abuse of their stories frequently. For the participants in this research I was able to listen with respect and empathy as they told their stories, emphasising the chapters they believed to be important and self-selecting what they were willing to share.

Increasing diversity among researchers has meant that established ideas about epistemology and methodology of research have been challenged. As a result, there has been an emergence of research carried out by researchers who are "insiders" or members of the communities and identity groups that they are researching (Kanuha, 2000). There is an inherent paradox in being an insider researcher; I needed to maintain connections with participants whilst I also needed to distance myself from my identity as a community participant (Kanuha, 2000). "If non-native anthropologists have difficulty in avoiding the superimposition of their own cultural categories and meanings, native anthropologists have the task of somehow distancing themselves, both intellectually and emotively (Ohnuki-Tierney, 1984, p. 584)." This became apparent for me through the use of insider language, and the possession of insider information. I tried to prepare for this scenario from the outset of the structured conversations by asking participants to make sure that they explained stories fully explaining that I could only include data they gave me. However, as I read through the transcripts I became aware of the times where I didn't ask enough, or require the participants to complete sentences and opinions.

SUMMARY

In summary, as I reflect on the aims of this research outlined in Chapter one, this study has amplified the voices of marginalised participants from the Caring Community through the presentation of their narratives focused on participation in the Caring Community. This has been done respectfully whilst upholding the values of the community. I have been able to use my academic opportunities to present their stories in such a way that their voices have been preserved and accurately represented, and also can be used to inform the decision making processes at a policy-making level. It has been shown that participation in the Caring Community is of great worth to the participants of this research, and why people ‘come’, ‘be’ and ‘stay’ engaged with the group. The intersectionality between participants’ engagement with the Caring Community and other aspects of their lives has been highlighted. The participants’ stories have shed light on ways that service provision to vulnerable people groups can be improved to hold them, their stories, and their strengths as the focus of engagement. Readers of this research will gain insight into the experience of participation in a socially-inclusive Christian Caring Community. I personally have a deeper understanding of the participants and the journey they have been on to get to the place where they are today.

CHAPTER SIX: CONCLUSION

Stories are the womb of personhood. Stories make and break us. Stories sustain us in times of trouble and encourage us towards ends we would not otherwise envision. The more we shrink and harden our ways of telling, the more starved and constipated we become (Mair, 1989, p. 2).

The concepts of belonging, social identity, community, and participation have been researched before and there is increasing information around the defining of these concepts. The identification of particular values that contribute to a space that fosters a sense of belonging is helpful, and listening to the specific stories of participants of the Caring Community delves deeper into the application of these values and how they are experienced on the ground. Narrative studies have an important role to play in the contextualisation of participants' experiences of caring communities. This study supports the view that narrative research approaches are an appropriate way to gain insight into the experiences of marginalised and vulnerable people groups (Clandinin & Connelly, 2000). I am in agreement with previous researchers who have advocated for marginalised people having the opportunity to share their own experience and also with researchers who take a critical and yet pro-insider research perspective. This study has been carried out in a New Zealand/Aotearoa context. In many ways this context sets the Caring Community apart from others around the world, due to the biculturalism of the country, the small national population and relative geographical isolation and therefore this study adds to the general body of knowledge as its findings have both similarities and differences with the literature that already exists.

This research makes contributions to the general body of knowledge, particularly with its multi-disciplinary interest in diverse people's experiences of being in reciprocal relationships with one another. The exploration of kaupapa Māori concepts, such as wairuatanga, and their application in a non-kaupapa Māori context helps to explore new ways of viewing spirituality. The way that people's prior experiences of exclusion and marginalisation impact their current journeys into participation and subsequently belonging are also explored.

LIMITATIONS

The sample size is small. Therefore the themes and insight that emerged from this study cannot be generalised across all people who participate in this, or similar, caring communities. It also cannot be assumed that all relevant themes for the participants of this study have been identified or explored to their full extent. By following participants' lead in what topics they chose to emphasise a broad volume of data

was accumulated. This, at times, results in a lack of depth of data from some participants on particular themes. The breadth of data provides possible avenues for further research.

The participant narratives each come from a single point of view only. In order to understand the context of the group more deeply, the stories of new Caring Community participants, and previous participants who were currently not participating would be valuable. Perspectives from non-participant whānau and friends of participants would also contribute to depth of insight. Due to the scope of this study these stories could not be explored comprehensively, but would contribute to a more comprehensive perspective.

Whilst there is diversity within the participants, all had traditional Christian influence in their homes growing up. It would have been worthwhile to hear the stories of participants who had differing faith, or no faith, input as children.

All of the participants in this study willingly volunteered to take part. It would be interesting to know if the results would have differed if I had been available during a normal gathering time and space of the Caring Community, for participants to more easily come and share their stories, then and there.

Finally, all participants were known to me prior to the initiating of this research. Had the researcher been an 'outsider', then those who volunteered to participate and what they shared may have been very different.

STRENGTHS

In-depth insight is provided into the experiences of seven adult participants of the Caring Community in this research. Through the participant stories we gain insight into what facilitated their ongoing participation in the community; such as safety, belonging and participation.

This study focussed entirely on the participants' point of view, providing subjective, real-life examples of what contributed to their sense of belonging. The participants' points of view were gathered respectfully, in a way that means there is shared gain from their uninterrupted story sharing. The portrayal of their narratives through accurate recollection of their words results in the participants having a wider audience for their stories than they usually would.

Rapport was established with participants prior to the commencement of the study as the research was carried out by an 'insider researcher'. This led to a willingness on behalf of the participants to share their stories.

The participants of this study diversely represented the make-up of the Caring Community. This in turn gave a breadth of data, due to their differing life experiences and current stages of life.

This study is unique in its use of narrative methodology with a combined focus on spirituality, belonging, and participation in the context of small-town Aotearoa. It has been conducted with a bicultural approach, consistent with the commitment to biculturalism held by the Caring Community and te Tiriti o Waitangi.

In this study space was created for people to share their own personal stories, uninterrupted, in their own words, their own time, their own space and their own way. This created a sacred space for the voices of those who have been frequently silenced by systemic oppression to be heard. This opportunity means that the participants are not turned into numbers on a page, but are respected as real people with a wealth of experience that is worth sharing.

Finally, the research question has been answered and the aims of the study have been fulfilled. The participant's stories have been heard, and respectfully retold whilst also upholding the mana and the values of the Caring Community. Participant motivations have been identified and specific factors that facilitate participation, safety, and belonging have been identified.

RECOMMENDATIONS FOR THE CARING COMMUNITY

To love another person is to see the face of God. (Hugo, 1980)

There is every reason why the Caring Community could take time to celebrate their collaborative story. It is evident that many participants find worth in their participation in the group, and their relationships within the group are mutual and beneficial. These kinds of groups need to celebrate the impact they are making in each other's lives and in the wider community. Have a party e hoa mā!

The Caring Community could be involved in presenting the findings of this research further afield, e.g. at regional and national Church gatherings. This would allow the community to take ownership of the findings, and also to give strength to the recommendations provided for other caring communities and churches.

The Caring Community could explore options for further story-telling opportunities as the story-telling process was valuable for the participants and for me as researcher, and potentially for any future ‘hearer’ of the stories. The re-telling of these stories in the narrative format presents powerful accounts of the lives of these participants. To share these with others in a less academic format would be a celebration of the stories included and an opportunity for a wider audience to engage with them. A book of ‘the people of the Caring Community’ could be collated, with a similar process being used to gather stories from more community participants.

Exploration of other opportunities for documentation of Caring Community specific information could be explored. The documentation of the Caring Community values and practices in written form has been significant for many participants. This style of documentation could be used for information such as the story of the community as a whole, its whakapapa, and how it came to be, and the book described above.

The finding that proactively including the excluded aspects of individuals within the group is valuable and can be further discussed by the Caring Community. The Community could consider what roles each person could have in making sure that happens for new people, how those people and the relevant parts of their identities could be identified, and whether this is a process that can be consciously enacted rather than subconsciously, as has happened up till this point.

RECOMMENDATIONS FOR DECISION MAKERS, CLINICAL PRACTICE, SOCIAL SERVICE PROVIDERS, AND CARING COMMUNITIES

If we want a change in culture, for example, the work is to change the conversation – or, more precisely, to have a conversation that we have not had before, one that has the power to create something new in the world (Block, 2009)

DECISION MAKERS

Legislation should not be made on the basis of statistics alone. There is already a lot of knowledge about marginalisation, mental health, and social exclusion available to decision makers. However, this knowledge tends to be held in the form of statistical data. Stories told first-hand of human experience are deeply powerful, and the point of view of the individuals with the lived experience of particular phenomena need to be put into the hands of the powerful, the decision makers.

People in positions of power need to consider their own upskilling in knowledge of te ao Māori including tikanga and te reo as a vital resource for contributing to the healing of the impacts of colonisation for Māori. Tauwiwi can play a significant role in the belonging and healing for Māori through genuine respect and acknowledgement of the mana of tikanga. This recommendation also extends to social service providers, clinicians, caring communities and Churches who are in a position where they can influence many people; Māori and Tauwiwi alike.

More time is needed for marginalised people to tell their stories. One aspect of this story-telling process is time for reflection. Participants of this research all reflected on what they said in the first structured conversation during the second structured conversation. They shared insights they had gained, or pieces of additional information they thought was relevant. Making sure there is time for client reflection in the process can be time-consuming. Most Social service agencies, and professionals, are aware of the value of long-term interventions. They are, however, constrained by funding and results-based accountability, therefore those who are in a position of stipulating the conditions on help-provision contracts need to emphasise the time required for these positive processes to occur. It is clear that by trying to expedite the process much of the key relational aspects are either underdeveloped or missed entirely. Relationships will always take time to respectfully build.

SOCIAL SERVICE PROVIDERS

Social services working with isolated or disengaged clients should consider referring clients to local caring communities. Referring to caring communities would be with the intended purpose of the client establishing social relationships and opportunities to reap the possible benefits of belonging, participation, and opportunities to contribute to the community.

Given the value for those who told their stories, for me, and potentially for readers in the future, I recommend that there be exploration of forums where more people can tell their stories, and also forums where people's stories can be presented back to them in a cohesive format.. Listening to the words and stories of others, and in particular marginalised people, is an influential experience, for both narrator and listener.

CLINICIANS

Clinicians need to make sure they do not lose sight of the inherent strengths in every client. If we work with clients from a deficit-focussed theory we will not necessarily get the depth of story which locates the

client as an agent of change in their own story. Clinicians need to allow clients the time and space to tell their own stories, not just the bits we want to hear or that fit within our own paradigm, to facilitate them into a role of power and autonomy in their own life.

It is important for clinicians not to lose sight of hope. Even when people appear to be complex and have multiple co-existing needs there is always hope for their future. In these situations relationships are key, not a focus on change. Therefore by either being in, or helping to facilitate and strengthen relationships that are mutual, respectful and allow each person to both give and receive help you are being part of a positive dynamic for that person.

Careful consideration needs to be given to specific language that is used when being with people, particularly those with prior experience of exclusion and marginalisation. Language is a very powerful medium, and in particular, people in positions of power need to pay careful attention to their choice of words. Respect needs to be given to the narrator, and to their stories. It is a call for those working in social agencies, within the church, and other institutions to seriously consider their personal and positional power. Consideration also needs to be given to how their language can either bring life to, or take life away from others.

CARING COMMUNITIES

Caring communities need to pay particular attention to establishing safety for participants. This includes physical, spiritual, emotional, and cultural safety. One way that this can be done is by clearly articulating the values and culture of the group in writing. This will look different for every community, and as such each community could benefit from doing this in their own way. Once safety has been established, in order to facilitate participation, a variety of opportunities that enable people to engage at their own pace and play to their individual strengths, should be provided.

People in positions of power within caring communities should not lose sight of the significance of apparently small things. This may be done by frequently inviting participation from people in a variety of ways, and noticing the contributions that participants make.

Caring communities need to clearly articulate the group values and intentions. The distance between an individual's initial values and the stated values of the Caring Community showed that when trying to affect change it is acceptable to have inconsistencies between the values of the group, and the participant, so long as the group values and their purpose are clearly stated.

RECOMMENDATIONS FOR FURTHER RESEARCH

We must not overlook the fact, that each of us is born with a story, and each of us has a responsibility to pass those stories on. To fortify our children and grandchildren, and help them cope with an increasingly material and technological world, we have to tell them the stories which reinforce their identity build their self-worth and self-esteem, and empower them with knowledge (Mita, 2000, p. 8).

Much of the literature I found when reviewing research for this study looked at themes such as participation and belonging from a clinical perspective and more could be done to include the voices of participants of groups and their particular point of view, especially when researching specific groups and communities in order to measure their efficacy as social interventions. To extend this further, the narratives of whānau of group participants could be included not only to deepen stories, but also to provide an additional unique point of view.

A similar research method could be used to seek narratives from participants of other socially-inclusive Christian communities. Many communities such as the Caring Community focussed on in this research, exist around the world, and even New Zealand, but they often operate under the radar and “on the smell of an oily rag” and this would help contribute to the limited body of documentation of these types of groups, and also provide findings to compare and contrast with those of this research. Defining, understanding, describing, categorising and comparing caring communities, such as this one, will continue to be difficult until more research on the communities has been done. This research would also help define the role that they play in the broader community and the lives of individual participants.

Similar research with more emphasis on Māori voice and kaupapa Māori research methodologies such as pūrākau could contribute further to the body of knowledge relevant in Aotearoa, and also when looking at health outcomes for Māori. This kind of research also needs to be carried out from a bicultural perspective, as most health and social service providers span both te ao Māori and the Pākehā world. The issues faced by participants of this Caring Community are not confined within one specific sector, rather they span the realms of physical health, mental health, social science, psychology, community development, housing, identity, poverty, and theology. The Community also involves people from minority and majority demographics, professionals and lay people, secular people and people of faith. Research into a group like this is best done from a holistic perspective, without siloed funding or perspective.

Further research would be helpful to explore whether inclusivity can be achieved across all demographics, or whether by emphasising inclusivity of one people group, e.g. marginalised people, another people group is unintentionally excluded, e.g. professionals. Participants of the Caring Community who had not experienced the same degree of marginalisation as others, at times expressed a reticence to share their struggles as they perceived them to be comparatively small or incomprehensible to others. This could simply be a sense they had as a result of their personal values or a reflection that the Caring Community's stated value of inclusion was not conveyed equally to all people.

There are many potential positives to conducting 'insider' research; these factors should be taken into account when selecting research methodologies. The strength of this research to bypass many of the rapport building processes that are necessary when asking people to tell their stories provided the opportunity to obtain rich, and personal data. Further to this, 'insider' research carried out within caring communities who have a different faith basis, i.e. not Christian, would provide further knowledge of the experience of participation in a Caring Community. This research would also enable exploration of the impact that having a different underpinning faith does, or doesn't, have on Caring Community experience.

Given that the reasons for the significance of the written booklet of tikanga and kawa are not clear, further research could examine why this was an important aspect of participants' engagement with the Caring Community and how this style of documentation could be used to aid the creation of 'safe spaces' in other contexts, for instance social services.

Research that explored the paradox described in the 'being' stage of annoying aspects of the Caring Community playing a role in new participants continued engagement could provide helpful insight. There was not sufficient information in the participant narratives to build a hypothesis about that from this research alone.

Reflective story-telling could be explored as a strengths-based treatment intervention designed to reconnect people with their stories and restore their sense of power and strength within them. As people who have experienced trauma are often disconnected from their stories, or the stories have become jumbled for them, stories can be an important aspect of their recovery and treatment.

Further research, possibly carried out by an 'outsider' researcher, could explore this further by specifically seeking out stories of less than ideal experiences, and also by having conversations with

participants who are still in the 'coming' or 'being' stages, and also those who have stopped participating. Participants of this research told overwhelmingly positive stories about their participation in the Caring Community. This may be an accurate reflection of their experiences, or perhaps they wanted to paint the community in a positive light, or felt unable to share negative experiences with me, a fellow participant, or maybe they saw this as an opportunity to support me in my academic endeavours. Perhaps by focussing our conversations on experiences which contributed to them further engaging with community I did not create space to hear negative experiences. This would be an opportunity to explore Pōwhiri poutama model as it uses the process of a pōwhiri to explain the different places people find themselves in terms of their readiness and willingness to engage and participate. Further research could also be done on how to implement this model in a non-clinical setting and within groups.

In essence this whole research is about relationships. We co-construct our identity and meaning in the space between us; we share stories because someone is listening; we hurt because we have been hurt; we love because we have been loved; and we care because we do not exist in a vacuum.

If I speak in the tongues of mortals and of angels, but do not have love, I am a noisy gong or a clanging cymbal. And if I have prophetic powers, and understand all mysteries and all knowledge, and if I have all faith, so as to remove mountains, but do not have love, I am nothing. If I give away all my possessions, and if I hand over my body so that I may boast, but do not have love, I gain nothing.(1 Corinthians 13:1-3, NRSV)

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APPENDICES

APPENDIX A ETHICAL APPROVAL



AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

17 June 2016

Warwick Pudney
Faculty of Health and Environmental Sciences

Dear Warwick

Re Ethics Application: **16/173 BELONG: A narrative inquiry into stories of participation and belonging to a community group.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 16 June 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 16 June 2019;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 16 June 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Adrienne Kerr adrienne.kerr@gmail.com



**VOLUNTEERS NEEDED FOR
RESEARCH STUDY.**

Journeys into Community

**Greenhouse Community
participants needed**

I am conducting research to hear people’s stories of participation in the Greenhouse Community

- You need to be: 18+, been a part of the Greenhouse community for 3+ months, and willing to talk about your life experience. If there are more people interested than necessary, participants will be chosen on the basis of representing the widest range of people.
- Each participant will need to have 2 interviews, of 1-2hours, each with the researcher, discussing why they came and what they have experienced
- The research is being done as part of a Masters of Health Science through Auckland University of Techonology (AUT)

Contact Adrienne Brewerton dabrewerton@gmail.com or 0221881767									
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APPENDIX C PARTICIPANT INFORMATION SHEET (COMPLETE)

Participant Information Sheet

This is the official information sheet for the 'Stories from the Greenhouse' research project. An additional information sheet in simplified form is available to aid understanding but please refer to this sheet for complete details.

Date Information Sheet Produced:
10 October 2015

Project Title
Journeys into Community

An Invitation
Ko wai au?
Ko Tatarua tōku maunga, ko Manawatu tōku awa, Nō Taitoko, me Whānganui-a-tara, me Oamaru ahau. Kei Taitoko tōku kāinga inaianeī. Ko Adrienne Kerr ahau.
My name is Adrienne Kerr and this is an invitation for you to participate in the research project I am carrying out. This project contributes to the Masters of Health Science that I am undertaking through Auckland University of Technology (AUT). This study is gathering the stories of adult participants of a socially inclusive Christian community group to hear about their experiences of participation. Being a participant in this study is voluntary and your choice to be involved or not will not affect your continuing participation in the group. If you choose to participate in the study but change your mind during it, you are able to withdraw from the study at any time prior to the completion of data collection, August 10th 2016.

What is the purpose of this research?
This research is intended to give a voice to the participants of the community group about their experiences of participation in the community. It is hoped that these stories and the presentation of them will give insight into the participants' journeys. This research will make up my thesis for submission as part of my Masters course. Articles will be written presenting the findings in journals, academic publications and presentations. The findings will also be shared with other similar communities.

How was I identified and why am I being invited to participate in this research?
You will have seen a flyer on the community's gathering place wall inviting you to participate. You will have identified yourself as having been a participant for a minimum of 3 months and being 18 years of age or older. To participate you need to be willing to spend 1-2 hours at a time in two interviews with the researcher focussing on your experiences of participation in the community group. If there are more people interested than necessary, participants will be chosen on the basis of representing the widest range of people.

What will happen in this research?
This project will involve you being interviewed about your story of participating in the community group and any affects you feel there have been in your life as a result of your participation. Interviews will take place in a private meeting room at the local library. These interviews will be recorded on a digital audio recorder and subsequently transcribed. You will be provided with a copy of the audio recording and written transcript to review, edit if necessary, and approve before it is used.

What are the discomforts and risks?
There is a possibility that someone you know may identify you from your story's inclusion in the research. You may share something with me that you later realise you would rather not have said. Sometimes telling stories about your life may involve thinking, or talking about some difficult memories. It can also be very tiring sharing your stories with someone.

How will these discomforts and risks be alleviated?
I will be changing specific details of your story to help protect your anonymity from readers. I will also be going through the transcript of our interview with you before going ahead with using it, that way if you have changed your mind about wanting to include something you have said you can identify it for me and we can remove it from the data. You will be in charge of your story that you give to me. If you find that the interview is becoming too tiring or too emotionally painful you will be able to stop at any point. If you require it I will help you to access



AUT
TE WHĀNGANUI A ARONUI
O TĀMĀKĪ MAKAU RAU

20 June 2017page 1 of 2This version was edited in July 2015

support services such as counselling if issues are raised for you that you want help to manage. Alternatively you can access it directly through, Living Well Counselling Centre, 29 Queen St West, Levin, 06 3682070.

What are the benefits?

There are benefits for you and for me. You have the opportunity to tell your story, and to be heard. This may result in the community group being able to better meet your needs, and the needs of others.

This research project will assist me to complete my Masters in Health Science. It will also help me to assess the value of my own participation in the community group. I am hoping that this project will be the foundation for further research.

How will my privacy be protected?

Consent forms and contact details will be kept in a locked cabinet. All identifying data will be removed from transcripts and your stories will not be written in any documents that also contain your details. Data will have identifying features removed and stored in a different locked cabinet from personal details and on a password-protected computer.

What are the costs of participating in this research?

There are no financial costs for participating in this research, however over the course of the next 3 months I will need to meet with you twice for between 1-2 hours each time.

What opportunity do I have to consider this invitation?

You have two weeks to think about whether you want to participate or not.

How do I agree to participate in this research?

If you are willing to participate in this research please notify myself on 0221639161 and give me your preferred contact details. I will then contact you and meet with you. You will need to sign a consent form that I will provide.

Will I receive feedback on the results of this research?

Yes, you will be notified by the contact method you select when the research project is completed. You will be provided with a written summary of the results and narratives constructed from them if you wish.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Researcher Contact Details:

Adrienne Kerr 0221639161

horwhenuacounsellingservices@gmail.com

Project Supervisor Contact Details:

Warwick Pudney +64 9 921 9999 Ext 7729

warwick.pudney@aut.ac.nz

APPENDIX D PARTICIPANT INFORMATION SHEET (SIMPLIFIED)

AUT

TE WĀHANGA A RONGU
O TAMAKAU MAKAU RAU

Basic Information

This sheet is additional to the official 'Participant Information Sheet'. The purpose of this sheet is to provide an overview of the study. You will be required to also read the 'Participant Information Sheet'.

Date Information Sheet Produced:
10 October 2015

Project Title
Journeys into Community

My name is Adrienne Kerr and I am studying at Auckland University of Technology. As part of my course I'm doing some research.

I'm wanting adults who are a part of the community group to talk to me about what it has been like to be part of it. I want to hear these stories so I can understand why people are part of the community.

I would like you to be part of this study if:

- you are willing to talk to me about what being part of the group has been like for you.
- you have been going for at least 3 months
- you are 18 or older
- you are willing to meet with me twice for 1-2 hours each time

If there are more people interested than necessary, participants will be chosen on the basis of representing the widest range of people.

It's up to you if you want to be in the study. It won't make a difference to whether you can be a part of the community. If you say yes, you can change your mind up until your interviews are finished.

Sometimes we might talk about difficult topics, or painful memories. It's okay to stop the interview. If you get too upset, I can help you find a counsellor to talk to.

Someone might be able to tell who you are from your story. I'll try to change all the details that might make it sound like you. I will also show you what you said and you can tell me anything you want to change. All the interviews will be kept locked up.

When this study is finished I'll be able to get my Masters in Health Science.

If you are in the study, you get to tell your story and have people hear about your story. You might be able to help the community group be better for you and for other people.

Please contact me on 0221639161 if you want to take part in the study. Then you and I will meet for you to sign a consent form and start the interviews. If you want to know about what I learn at the end, you can tell me and I'll give you a copy of the things I learnt.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Warwick Pudney +64 9 921 9999 Ext 7729 warwick.pudney@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

If you want to know more you can call, text, or email me, Adrienne Kerr
0221639161 horowhenuacounsellingservices@gmail.com

Project Supervisor Contact Details:
Warwick Pudney +64 9 921 9999 Ext 7729 warwick.pudney@aut.ac.nz

Please also read the 'Participant Information Sheet'

APPENDIX E CONSENT FORM



Consent Form

Project title: **Journeys into Community**

Project Supervisor: **Warwick Pudney**

Researcher: **Adrienne Kerr**

- I have read and understood the information provided about this research project in the Information Sheet dated 10 October 2015.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- I understand that in the event more people offer to participate than are required, I may be excluded from the study on the basis of participants being chosen to represent a diverse range of participants.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes No

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 19/05/2016 AUTEK Reference number 16/173

Note: The Participant should retain a copy of this form

APPENDIX F STRUCTURED CONVERSATION OVERVIEW AND PROMPTS

Intro/Karakia

Starting Questions

- Gender, Sexuality
- Age
- Religion/faith/culture
- Employment hx/current, daily activities
- Any other important things that make you you
- How you come to be in Levin now, living situation
- Define health, and well-being
- Are there any particular issues Levin people face around health?

Beginning

Focusing on life before participation, and interest in the group

- 1st heard of GH
- 1st attended
- What interested you about it?
- What did you think you were going to? How was is same/diff
- Looking back, what about your life made you the kind of Person who would be interested in GH?
- Have you gone to churches/community groups before?
- How was GH similar/different to those?
- Tell me about an early event at GH
- What is a memory that stands out from early on?

Middle

Focusing on attending the group and joining in

- You continued to go, why was that?
- How did you feel about being a part of GH?
- Describe a typical/normal GH experience
- How is GH same/diff from other things you do?
- You could be doing other things with your time, why GH?

End

Focusing on the individual's choice to stay and identify as a participant of the co

- Tell me what you think it means to belong to GH?
- How would you describe yourself in relation to GH?

Topic Areas and Synonyms

Participation

Belonging

Community

Health

Connectedness

Faith

Te Ao Māori

Social Identity

Inclusion

Support

Sharing

Encouragement

Taking part

Security

Relationships

Hope

Safety

APPENDIX G THANKYOU LETTER

Dear

Journeys into Caring Community Research Project

This letter is to thank you for being willing to participate in the research project on the Greenhouse Community.

It was truly an honour to be able to hear the stories that you so generously shared with me, and I hope it was a positive experience for you also. The time that you gave me, and the openness with which you shared your experiences was immeasurably helpful, without you I would not have been able to complete this research.

I would like to reiterate my offer from the beginning, that should you wish to ask me any of the questions I asked you about my experience of participating in the Greenhouse Community you are more than welcome to do so.

I have enclosed a small koha, to acknowledge the time and energy you gave to me. It was approved by the Ethics Committee from the beginning, but was not appropriate to give to you until the structured conversation process had been completed.

I will be in contact again after the submission of my research to provide you with the written summary of my findings.

Once again, Thankyou for choosing to take the time you did, and to trust me with your stories. I am very grateful.

Ngā mihi nui ki a koe,

Adrienne Kerr

APPENDIX H GLOSSARY OF TE REO MĀORI WORDS AND TERMS

Glossary of Māori words and terms in alphabetical order

Definitions for non-asterisked kupu were sourced from the online Te Aka Māori-English Dictionary. www.maoridictionary.co.nz

Definitions for asterisked kupu are by the researcher, based on the context of the source being quoted.

Aotearoa	Māori name for New Zealand
Aroha	Love, affection, sympathy, charity, compassion, empathy
Atua	God
E hoa mā*	Friends
Hoa haere*	Constant companion
Kai	Food
Kāinga	Home, address, residence, village, settlement, habitation, habitat, dwelling
Kaitiaki	Guardian, trustee, minder, guard, custodian, caregiver, keeper, steward
Kaputī	Cup of tea.
Karakia	Prayer
Karakia mutunga	Closing prayer
Karakia tīmatanga	Opening prayer
Kaupapa	Topic, policy, matter for discussion, plan, purpose, scheme, proposal, agenda, subject, programme, theme, issue, initiative
Kawa	Protocol, customs
Kāwhe	Coffee
Kupu	Words
Mana	Prestige, authority, control, power, influence, status, spiritual power, charisma - <i>mana</i> is a supernatural force in a person, place or object. <i>Mana</i> goes hand in hand with <i>tapu</i> , one affecting the other
Manaakitanga	Hospitality, kindness, generosity, support - the process of showing respect, generosity and care for others
Mātauranga	Knowledge, wisdom, understanding, skill
Mauri	Life principle, life force, vital essence, special nature, a material symbol of a life principle, source of emotions
Mauri oho*	A stage of potential, change, and instability, spiritual awakening
Ngākau tapatahi	Integrity, impartiality, neutrality, fairness, even-handedness, non-partisanship
Pākehā	English, foreign, European
Poutama	Stepped pattern of tukutuku panels and woven mats - symbolising genealogies and also the various levels of learning and intellectual achievement
Pōwhiri	Rituals of encounter, welcome ceremony on a marae, invitation, welcome
Pūrākau	Myth, ancient legend, story
Pūrākau*	Narrative
Rangahau painga*	Ethical framework

Rangimarie	Peace, peacefulness, harmony
Raruraru	Trouble, problem, dispute, conflict
Taha	Part, portion, section, aspect
Tangata	Human, individual
Taonga	Treasure, anything prized - applied to anything considered to be of value including socially or culturally valuable objects, resources, phenomenon, ideas and techniques
Tapu	Sacred, prohibited, restricted, set apart, forbidden, under <i>atua</i> protection
Tauiwi	Foreigner, european, non-māori, colonist
Te Ao Māori*	Māori worldview
Te kōrerorero	Dialogue, conversation, discussion, chat
Te mahara*	Reflection
Te reo Māori	Māori language
Te reo Pākehā	English language
Te rongo*	Intuition
Te Wā*	Significant moment
Te wetewete*	Analysis
Te whiriwhiri	Negotiation, discussion
Tikanga	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention, protocol - the customary system of values and practices that have developed over time and are deeply embedded in the social context
Tino rangatiratanga	Self-determination, sovereignty, autonomy, self-government, domination, rule, control, power
Tiriti o Waitangi	Treaty of Waitangi
Tohitohia*	The ability to share
Tuakiri	Person, personality, identity
Tuakiritanga	Inner-being
Waiata	Sing, song
Wairuatanga	Spirituality
Whakaaro	Thought
Whakamā	Ashamed, shy, bashful, embarrassed
Whānau	Extended family, family group, a familiar term of address to a number of people
Whanaungatanga	Relationship, kinship, sense of family connection - a relationship through shared experiences and working together which provides people with a sense of belonging.