LUND UNIVERSITY

Caring for the Caregiver

Understanding the quality of the Te Whare Awhina service from the residents' perspective

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Abstract

When a person becomes a patient in the Auckland City Hospital, the largest public hospital in New Zealand, they often bring one or more family members with them for mental and physical support. This thesis focuses on these support persons, who in this thesis are referred to as the patient caregivers and their perspectives on staying at *Te Whare Awhina* (TWA). TWA is an accommodation provider run under *Māori* protocol for carergivers of patients in the Auckland City Hospital who live outside of the Auckland Region. As a rule patients and their caregivers undergo serious personal crises during their stay at the hospital due to being in an unfamiliar environment and an unpredictable situation. This thesis asks how the caregivers can best be supported and approached when they are in distress.

Observations, semi- structured interviews, auto-ethnography and photo-ethnography were used to gather the empirical material for the cultural analysis of what TWA is and how it supports the carergivers of patients in the Auckland Hospital.

This thesis found that TWA is a heterotopia, since the service has a unique function as it cares for the carergivers of adult Auckland City Hospital patients; it provides accommodation and interpersonal support for them. Also TWA is influenced by a female ethics of care and the *Māori* Value system, which means that certain values are associated with the TWA staff being female and their way of performing care, certain qualities of which also connect to the *Māori* worldview through which TWA needs to be understood.

The thesis also analyses the individual experience of being a caregiver staying at Te Whare Awhina in terms of a journey rather than a fixed stay. During their stay caregivers learn to establish daily routines and how to move between different centres and peripheries in order to cope and survive their crisis. Furthermore the social interaction between caregivers and between caregivers and the *Māori* staff is crucial to the quality of the service of TWA; for example the issue of belonging is discussed, which is constituted through the informal set up of TWA, the buoyant attitude and professionalism of staff, a shared understanding between caregivers and their (often) similar cultural identity. Finally, the significance and application of ethical values in this type of research is also stressed.

The thesis results are first and foremost communicated back to Te Whare Awhina to apply in their service, but may be used by other institutions providing similar services. Researchers and health care professionals might employ these findings to understand and create an optimal environment for patients' caregivers in a variety of settings.

Keywords: Patient- family centered care; patient support; care giving; heterotopia, female ethic of care; *Māori* value system; belonging, ethics, centre and periphery; travel.

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This thesis would not have been possible without the support from the entire *Te Whare Awhina* team who always had an open door policy for me. Without their trust and patience to answer my many questions I would not have been able to undertake this project. A special thank you also goes to Point Research (Auckland/New Zealand) especially to Alex Woodly and Nadine Metzger, who offered me the best internship anybody could ask for and put me into first contact with *Te Whare Awhina*. Also I thank my supervisors at university for allowing me to gather the empirical material and write this thesis approximitely 17522 km away from Sweden. I also want to thank my caring family, my friends all over the world and my partner for listening to me and helping me in any ways they could. A special thank you goes to Kasia Herd who has always made sure that I got all the information I needed from the MACA seminars in Sweden.

Wismar, 2013-05-29

Miriam Gottschalk

Definition of terms

My research was conducted at a *Māori* service. To show my respect for the wonderful culture I have learnt so much about in the last months I will utilise some *Māori* terms throughout this paper that can be described in English and other languages but no justice can be done to their meaning by word-to-word translations.

Awhi

Awhi is one of the three main values of the *Te Whare Awhina* service. It can be translated into English as support or help.

Kaupapa

Can be translated as policy or agenda. *At Te Whare Awhina* the *kaupapa* is built around supporting the individual.

Manaaki

Manaaki is one of the three main values of the *Te Whare Awhina* service. It can be translated as care, respect and kindness towards others.

Māori

Māori are the native people of New Zealand. Māori can be translated as native, indigenous and belonging to *Aotearoa*/New Zealand, without restraint.

Pākehā

Pākehā is a term in *Māori* language for New Zealanders who are of European descent. Some use *Pākehā* to either refer to any fair-skinned person, or to any non-Polynesian New Zealanders. In this thesis Pākehā refers mostly to New Zealanders of European decent.

Te Reo

Is the language spoken by the *Māori* people in New Zealand

Te Whare Awhina

This name can be translated as the House of Support, or how one resident has said the house of coming together. Wrap around care, compassion and empathy are embedded in this place.

Whare

Is the short version for *Te Whare Awhina*. It can be translated as house and often staff and residents have referred to the facility as their *whare*.

Whānau

Is one of the three main values applied by the *Te Whare Awhina* service. This term is used for describing the family and extended family, or a family group. It can also be an expression to address a certain number of people. Residents often consider *Te Whare Awhina* as *whānau* environment, were strangers become friends over a cup of tea and establish relationships that feel like *whānau* connections.

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CHAPTER 1- Introduction

Thursday, 22nd September

Without Te Whare Awhina I wouldn't have been able to visit with my young brother in what will probably be his last days. With all the stress around his illness and also the distance from home this place has enabled me to sit with him for an extended time without any extra problems and concerns. Thank you so much also to the Whānau (Maori term for family) at Te Whare Awhina. The staff and the fellow visitors have made it feel a second home.

Victor Sanders

When I was at *Te Whare Awhina* for the first time I immediately felt welcomed and I felt as if I was in a 'good' place where people care and lookout for each other. *Te Whare Awhina* is an accommodation provider run under *Māori*[1] protocol for carergivers of patients staying in the Auckland City Hospital (New Zealand) who live outside of the Auckland Region. I had a look around the building and noticed the message above in the visitor's book placed at the entrance of the *Whare*[2]. I was overwhelmed by this warm feedback and several more messages in this visitor book had a similar tone that I got very curious to find out what it was about the place that made its residents comment so positively on it. Consequently three months after my first visit to *Te Whare Awhina* I returned to undertake fieldwork for my thesis there. It was my goal to find what constituted the quality that I got the impression was attached to this services. The resulting thesis centres on this quality/value of the *Whare*. I was fascinated by the way *Te Whare Awhina* operates, by the kindness, care and love embedded in this place. In this lies my personal motivation for writing my Master thesis about this accommodation provider, as I believe places like this are in many ways a backbone of humanity. Furthermore there is a need to discuss this caregiver support centre from a socio cultural analytical perspective. That is due to the fact that nominal research has been undertaken on these services and hence there

[1] *Māori* are the native people of New Zealand

[2] *Whare* is the short term for *Te Whare Awhina*. It can be translated as 'house'

is a nominal understanding of basic cultural patterns and concepts that exist in these places. Cultural analysis creates this understanding, which in return creates outcomes to support the argument for the importance of such services in society.

The thesis is structured as followed: firstly I discuss the background of my thesis topic; second, previous research and theoretical frameworks are introduced. Thirdly, the methodological approach will be reflected upon and then in chapter's six to nine the findings are presented and analysed. Chapter six asks what *Te Whare Awhina* is. Chapter seven elaborates upon the individual experiences and Chapter eight focuses on social interaction. The emphasis of chapter nine is on ethical considerations and associated challenges emerging during this research. Lastly a concluding chapter is presented and a summary is here provided to bring together the main points of this thesis.

CHAPTER 2- Background to this study

A brief introduction to *Māori* history

Throughout this thesis I discuss *Te Whare Awhina* as a *Māori* institution. *Māori* are the native people of New Zealand who are believed to have first arrived in New Zealand during 1250-1300 CE from Polynesia (Howe, 2006). With the arrival of European settlers starting in the 17th century *Māori* faced enormous transformation in their way of life as from then on *Māori* gradually had to adopt to Western Culture (Howe, 2006). In 1840 the Treaty of Waitangi was signed, which acknowledged *Māori* and European as two coexisting cultures in New Zealand. Conflict over land issues, introduced epidemics and diseases and social upheaval led to a strong decline in the *Māori* population (Howe, 2006). However during the 20th century *Māori* population began to recover as more effort was put into giving them their place in New Zealand Culture and since then *Māori* culture has enjoyed revival (Howe, 2006). *Māori* make up around 15 percent of the national population and a quarter of all *Māori* speak *Te Reo* (the *Māori* language) (Howe, 2006). Now *Māori* are actively involved in all levels of the New Zealand society, having an independent representation in politics, sport and media. However *Māori* encounter social and economic obstacles, having lower life expectancies, incomes and education, higher crime rates and health problems compared to other New Zealand ethnic groups. There are socio-economic efforts implemented to close the gap between *Māori* and other New Zealanders. *Pākehā* is the *Māori* term used for the first European Settlers. Some people use this term to either refer to any fair-skinned person, or to any non-Polynesian New Zealanders. In this thesis *Pākehā* refers mostly to New Zealanders of European decent. At the centre of the *Māori* value system is care, which calls for humans to be *kaitaki*, caretakers of the *mauri*, the life force, in each other and in nature (Spiller, Erakovic, Henare& Pio, 2010, p.1) . Key concepts of *Māori* society include *manaaki*, the cultural obligation to welcome and care for visitors (Robinson, 2001).

Te Whare Awhina is a *Māori* service and strongly lives the *Māori* value system (Staff interview, 2012). In chapter six more in-depth information on *Māori* culture, gender

roles and the *Māori* ethic of care will be presented as the service cannot be understood without providing this information. This thesis attempts to offer insights to the *Māori* culture and the associated value system to the outside world and does not focus on economical or political issues that arose out of colonisation for *Māori*. Even though these dimensions are very important, in this cultural analytical study on *Te Whare Awhina* I was limited by the research frame and had no resources to focus on these.

Describing *Te Whare Awhina*

This thesis discusses '*Te Whare Awhina'*, the 'House of Support. ' It is an accommodation facility located on the site of the Auckland Hospital, New Zealand. It provides temporary accommodation for caregivers of patients staying at the Auckland hospital, particularly those living outside of the Auckland Region. Guests of *Te Whare Awhina* come from all around New Zealand and the world. Often patient caregivers arrive at the facility in extreme distress due to their family members being dangerously ill. For instance, the patients can be victims of heart failure or serious car accidents, which requires that they and their caregiver be rushed to the hospital in rescue helicopters, without any prior warning. In this thesis the term 'patient caregiver' refers to a *whānau*[3] member of the patient in the Auckland Hospital who mentally and physically supports this patient during their stay. However patients also travel to Auckland for elective surgeries from all over New Zealand and the Pacific Islands (such as Samoa, Fiji or Vanuatu). Also in these situations patients bring one or more family member for mental and physical support.

Te Whare Awhina is a service run under *Māori* protocol; it provides accommodation for *Māori* and non-*Māori* patient caregivers. The management consists of John Paterson who is the overall manager of the facility and Janie Ingram who is the team leader. There are three staff members on sight to interact with the residents, provide them with information, and offer help with any issues they have. These are Christine Fran, Megan Peita and Laura Furly. All team members identify themselves as *Māori*. For the residents, these staff members are the first point of contact at the *Whare*, the residents identify them as 'guardians' of the facility. They are on sight and they

[3] *Whānau* is the Maori term for family, extended and perceived family.

actively offer support to residents. *Whānau* (family and extended family), *manaaki* (care, respect and kindness) and *awhi* (help or support) are the most important values of the facility (Auckland District Health Board, 2003). There is no limit on stay at *Te Whare Awhina*. Some guest stay for a night and others for many months depending on the state of the patient. No charge applies for New Zealand citizens as the Auckland District Health Board (ADHB) and the local health boards where the New Zealand patients have their residency cover their expenses. The fee for international guests is $40 a night. There are 16 rooms (Staff interview, 2013). Due to capacity issues some rooms can be turned into shared accommodation to allow for more guests to stay at the facility. *Te Whare Awhina* can comfortably host 16 families (maximum of three members from each family) and can accommodate a maximum of 21 families (Staff interview, 2013). The service provides bedding, towels, laundry and basic foods (such as bread and milk).

Aim and Rationale

The research conducted for this thesis consisted of two parts. The first part was defined by the work I undertook during my internship for this Masters degree. The second part is the empirical research I conducted independently after I completed my internship. As I worked at a Social Action Research Institute, with the employees emphasising their work on conducting qualitative research it came naturally to all of us to have a qualitative approach to the research at *Te Whare Awhina*. It became the main aim of my thesis is to define the quality of the *Te Whare Awhina* Service by investigating how the caregiver can be best supported and approached when they are in distress to identify the impact this service has on the residents' wellbeing and hence the effects that has on the wellbeing of their patients.

Within this main objective I will discuss the main characteristics and associated values of *Te Whare Awhina* and elaborate upon the impact this has on the residents. The residents' experiences at the facility will be analysed to understand the patient caregivers' perspectives on what it is like to stay at this accommodation provider. Belonging through social interaction will be reflected upon, as a major quality of the facility was discussed within the context of being with and around others. Knowledge

gained on how to conduct ethical research with informants in crisis will also be displayed in this thesis as this fieldwork has revealed new insights into undertaking research with participants in a personal crisis. Research questions are:

- What is care at *Te Whare Awhina* and for whom?
- How can the experience of the caregiver at *Te Whare Awhina* be understood?
- What significance does culture and gender have in understanding care at *Te Whare Awhina*?
- What are the effects of social interaction on patient caregivers at *Te Whare Awhina*?
- How can research informants in crisis be understood and best approached?

Insights gathered in this thesis explain what matters to residents and can support an understanding of how to create a best practice in terms of accommodating patient caregivers. Providing these caregivers with the best support possible allows them to be the best sanction for their patients.

Significance and Greater motivation of this research

These insights are most useful to *Te Whare Awhina* as this research is tailored around their needs. However other facilities offering a similar service can utilise these findings to argue for the importance of their service (for example, in funding, education and advertising matters). However as this thesis also valuable for social scientists, researchers and health care professionals as it offers insights into the behaviour of individuals when they are in serious personal crises and how they can be best supported and approached when they are in distress.

The *Te Whare Awhina* management requested to use some of this research to support the argument for necessary upgrades and renovation of the accommodation unit to bring these findings foreword to their funding agency, the Auckland District Health Board. Their request has influenced my navigation through this research and was a major motivation for conducting the research.

CHAPTER 3- Previous research and theoretical framework

This research positions itself within the field of medicine and fits in the research area of ‘patient- family centred care’. At the core of patient-family centred care is the belief that families and health care professionals are partners and work together to meet the needs of the patients (IPFCC, 2011). A fair amount of research has been conducted on patient- family centred care, both in terms of qualitative and quantitative approaches. This form of looking after patients redefines the relationships in health care as it acknowledges the vital role of family support in the wellbeing of family members in all ages (Kelleher, n.d.). It acknowledges that emotional and social supports are vital components in a health care plan (Robinson, Calister, Berry& Dearing, 2008).

Research that has been conducted on Patient- family centred care concludes that personal values, preferences and needs of the patients should be a key domain in any health care. The core principles have been identified as respect and dignity, information sharing, participation and collaboration in this model of care (Robinson *et al*, 2008). Patient- family centred care has been applied for example in the health care areas of Adult Health Care, End of Life Care, Health Information Technology, Maternity Care, Paediatric Care, Patient Safety and Facility Design, (IPFCC, 2011). Many case studies have been undertaken, especially in the context of children and senior citizens. Many frameworks have been developed that allow health care providers to become more patient family friendly services. Within patient family centred care it is an important guideline to understand care as an experience of the patient and as an experience of the family member as well (DiGioia, Embree, & Shapiro, 2012). So far, services like *Te Whare Awhina’s* have received nominal attention within academic research. However they are part of the broader concept of transforming health care to be more patient- family oriented, as these services exist only due to this understanding.

A fair amount of qualitative and quantitative research has been undertaken on patient family- centred care in previous literature (Robinson *et al*, 2008). The qualitative research was often conducted in the forms of interviews and focus groups;

quantitative research was most often undertaken in the forms of surveys and questionnaires. Patient family centred care is mostly discussed within the nursing and rehabilitation literature. The focus within Patient- family centred care has been dominantly on the relationships of patients, families and health care providers on a clinical level (IPFCC, 2011). Foster, Armstrong, Buckley, Sherry, Young, James-Hohaia1, Theadom, McPherson (2012) have backgrounds in psychology, occupational therapy, neuropsychology, strategic health advisory and government work and are employed *inter alia* by the Auckland University of Technology and the New Zealand Rehabilitation Ltd. (Foster *et al*, 2012). Coming from these medical and political backgrounds these authors conclude that despite the agreement that families should be involved in the rehabilitation process of their *whānau* there is only limited evidence to underpin guidance for services on the most effective ways that they can support patient families to be the best support possible for their *whānau*. This thesis adds knowledge to exactly this area of patient- family centred care from a cultural analytical viewpoint. For my thesis the previous literature aids as a foundation to grasping the key domains of this medical research field and it allows me to look at areas that have not been assessed yet in medical studies. I have found no research that focuses merely on the effects a supportive accommodation unit can have on the wellbeing of patient caregivers. In this I was able to find a niche where I can add new information to medical research. By looking holistically at the patient caregivers, their personal crisis and their wellbeing this thesis intends to look at patient- family centred care through the eyes of the caregiver and thereby adding new knowledge to medical research. This is where this thesis contributes cultural analytical insights to the field of medicine.

To understand *Te Whare Awhina* as a specific space Foucault's (1967) concepts of a heterotopia are utilised. In particular the focus is on 'crisis heterotopias' which are a places reserved for individuals in a state of crisis (Foucault, 1967). Heterotopias are places that exist "*outside of all places, even though it may be possible to indicate their location in reality*" (Foucault, 1967, p.1). Heterotopias exist in all cultures and they have a unique function, which can change as society changes (Foucault, 1967). Furthermore the understanding that heterotopias bring together in one space different, often juxtaposing spaces is an understanding utilised in this thesis. Within heterotopias time is often perceived differently to the outside world, and these spaces

presuppose systems of opening and closing (Foucault, 1967). Hamilton (2011) '*Caring/Sharing': Gender and Horizontal Co-ordination in the Workplace*' and Robinson (2001) '*Social capital and voluntary activity: Giving and sharing in Māori and Non-Māori Society'* will be utilised to discuss gender issues and cultural matters. Lefebvre (1991) '*The production of space'* will also be employed to deconstruct the inside space of *Te Whare Awhina*.

'*Regionauts, The Transformation of Cross- Border Regions in Scandinavia'* by Löfgren (2008) will be employed to discuss caregiver experiences. In this article borderlands with a focus on the Oresund region are discussed (Löfgren, 2008). Löfgren (2008) discusses physical borders and bridging borders. Löfgren (2008) states that bridges can nourish inclusion and exclusion at the same time. In my thesis I will discuss inclusion and the effects it has on the individual experiences of *Te Whare Awhina* residents. In moving between centres and peripheries, between physical and mental borders short term and long term effects on the individuals can appear. Löfgren (2008) acknowledges that new skills often develop when crossing borders. In my thesis I will reflect upon this understanding. Further theories utilised within this context are *'The Secret World of Doing Nothing'* by Ehn and Löfgren (2010) and '*Place attachment, sense of belonging and identity in life history narratives of Iranian Baha'i refugees*' by Williams (2009).

'*The Presentation of Self in Everyday life'* by Goffman (1969) will be looked at to analyse social interaction and group behaviour. Goffman has dealt extensively with the interaction of individuals in social settings. According to Goffman (1969) when an individual comes into contact with another one than this individual will try to create an image of the self that he/ she wants to represent. Simultaneously the other individual tries to receive information from his opponent. For Goffman (1969) social interaction is defined by individuals performing certain roles to portray a certain images of who they are. His ideas on 'frontstage' and 'backstage' behaviour of individuals create a framework for my analysis to discuss social interaction at *Te Whare Awhina* and help explain the nature and outcomes of relationships, how they emerge, function and how they are perceived by the individuals at *Te Whare Awhina.* Furthermore '*The Scientific Study of Social Behaviour'* by Argyle (1957) will also be utilised in this section.

To reflect upon ethical considerations Hofmann (2004) "*Towards critical research ethics: Transforming ethical conduct in qualitative health care research*" will be utilised to get an overall understanding of what ethical concerns in health care research. Daley (2012) "*Gathering sensitive stories, Using care theory to guide ethical decision-making in research interviews with young people*" stresses some fundamental ethical challenges in the type of fieldwork were sensitive experiences are revealed and will hence also be utilised. Davies (2008) "*Reflexive Ethnography, a guide to researching self and others*" discusses ethical reflectiosn and will therefore also be considered in this thesis.

CHAPTER 4- Methodological approach

In this section cultural analysis and qualitative research will shortly be introduced to provide a context for the methods used within the fieldwork for this thesis. Personal ethical guidelines and the related impact this had on my choice of methods will be discussed. Furthermore each method utilised will be discussed more in-depth within this section.

Cultural Analysis as a departure point

When I started to undertake this Master in Applied Cultural Analysis I knew very little about cultural analysis and qualitative research. However over the last two years I gained an in-depth understanding of studying culture, for the complex 'thing' it is. Culture as Hannerz (1992, p. 4) states has three dimensions: "*Ideas and modes of thought"* as processes in the human mind, "*forms of externalisation"* which are the varying ways in which meaning is created, and "*social distribution",* the ways in which the former two dimensions are spread over a population. Cultural analysis is particularly interested in understanding the first dimension, as it is in this dimension that concepts, prepositions, values and the various ways in which ideas are handled are constructed (Hannerz, 1992). In undertaking cultural analysis at *Te Whare Awhina* I was concerned with grasping values and to identify existing cultural patterns at *Te Whare Awhina*, in this I examined the first dimension in depth. Qualitative research is the foundation of conducting cultural analysis; it "*involves investigation beyond the superficia*l" (O'Toole & Were, 2008,p. 616). As qualitative researchers it is our goal to retrieve a thorough understanding of human behaviour, the reasons and the causing of behaviour (Babbie, 2007). Qualitative research methods are concerned with answering the how and the why rather than just the where, what and when of decision-making (Babbie, 2007). As Babbie (2007) states qualitative research enables the researcher to investigate social life in its natural habit.

As mentioned earlier the research for this thesis constituted of two parts. Part one was defined by the research undertaken during my internship and part consisted of the

empirical research conducted later on merely for the purpose of this thesis. During the internship we conducted a 60-minute focus group interview with the entire *Te Whare Awhina* team. The material gathered from this research and a book created by *Te Whare Awhina* residents called '*Te Whare Awhina- Whānau thoughts, reflections and recipes*' were the starting point for this thesis. In my empirical research I conducted observations, informal semi-structured interviews, focus groups photo ethnography and auto-ethnography to get a thorough understanding of the *Te Whare Awhina* service and its residents. I used multiple methods to ensure a robust triangulation of data. All my Methods were inclusive and participatory.

People in medical emergencies are most often in distress and undergo some kind of personal crisis; therefore I aimed to minimize the impact of my research on them. I did not have to wait for getting ethical approval from the Auckland District Health Board, which is usually a lengthy procedure and taken very seriously in New Zealand, as my research emphasised understanding health services and patient support rather than patient experiences. In all the methods applied for this research I constantly tried to create a balance between getting the best/ most authentic insights and to regard the wellbeing of my informants. Below I also discuss how certain ethical reflection might have influenced the outcomes and associated limitations are displayed.

Methods- cultural analytical tools

By undertaking observations, interviews, photo ethnography and auto ethnography I ensured a robust triangulation of data and gained a complex understanding of what matters to patient caregivers. Perhaps the findings gathered with the help of these methods can act as a foundation to produce surveys and questionnaires of a more quantitative nature in case statistics and percentages are a desired outcome.

Observations

The first two days I was mainly focused on conducting observations at *Te Whare Awhina*, to get a 'feel' for my research field and to gain first insights to potential research participants and their environment. Generally speaking, in observing any space you examine a location "*where people do things*" (O'Toole & Were, 2009,p.

616). Observing space therefore gives you insights into the things people do, how and potentially why they do them. The first two days I undertook observations from 7.45am to approximately 9pm, mostly in the kitchen/lounge area of *Te Whare Awhina* as I identified this to be the main place for residents to gather. I introduced myself and this research project to every newcomer and besides that I stayed in the background, sitting in one corner of the kitchen area with a cup of tea and my laptop open, silently observing everything that happened. Most residents spent their early mornings and late evenings at *Te Whare Awhina*, during other times of the day residents were most often with their patients in hospital. Consequently after the first two days I started to conduct my research from 7.45am to 1pm and from 5pm to 10pm for the following 12 days. I simultaneously conducted interviews from the first day onwards as residents were very eager to share their experiences with me. As Tjora (2006, p. 429) states: "*Through observations [...] the researcher gains a partially independent view of the experience on which the respondent's language has constructed [...] realities*". *Inter alia* the combination of interviews and observations made it possible to see the differences in people's comments and their actual behaviour.

I identified observations in combination with interviews to be the most valuable tool as it allowed for a complex view on the behaviour of *Te Whare Awhina* guests. In my research, context observations were crucial as they helped me to determine the stress levels of individuals and hence showed me whether approaching an individual regarding my research would be appropriate or not. When dealing with informants in crisis I identified observations to be crucial for conducting ethical research. This is due to the fact that body language reveals respondents' stress levels and hence their readiness/ non readiness to participate in conversation. However I also realised that observations were best used as a complimentary method in research as on its own this method did not tell me enough about the respondents' perceptions and decision-making. In my thesis context, information retrieved only from observations would have become too descriptive and superficial and would not have given sufficient grasp of the caregivers' thoughts and values on the facility.

Interviews

As part of my own research I have conducted 18 in depth interviews (30minutes-60minutes in length), in the form of casual conversations with *Te Whare Awhina* residents. 15 of a total of 19 of the respondents were female and four were male respondents. 11 of my informants identified themselves as *Māori*, or partially *Māori*, from all around New Zealand. I also talked to six *Pākehā*[4] from throughout the country, to one female from the Cook Islands and to one Caucasian female from Perth/ Australia. 13 or my respondents were over the age of 40. Therefore most of my interviews were conducted with New Zealanders (*Māori* and *Pākehā*) being female respondents and over the age of 40. This represented the demographics that were identified by *Te Whare Awhina* Staff as most common at the facility.

I intended to keep my interviews as informal as possible to put a nominal amount of stress or pressure on the informants. I did not arrange specific meetings with the informants; interviews emerged spontaneously over a cup of tea as I identified this to be the least stressful way of conducting interviews at the facility. Davies (2008, p. 105) states that ethnographers who emphasise a major part of their research on observation often conduct interviews rather in the forms of "*naturally occurring conversations*". Reflecting on the style of interviewing undertaken I now realise that it was unavoidable in my research context. Now I have to admit that it might have been less intentionally applied than just unintentionally occurring. Residents approached me, as they wanted to share their experiences at *Te Whare Awhina*, they wanted to provide their feedback and in that wanted to do their share in supporting the facility. Often it was a matter of let us talk 'now or never' as many residents were at the *Whare* for or only a day or two. I identified this interview style to be the best interview method in my research context. Potentially a structured interview might have lead to more coherent information, easier to compare, but it would have lacked the different angles and views that I gained through asking questions out of the rigid format. Interviews were semi- structured as I prepared a set of questions to ask but it was in the spontaneously evolving questions that I gained the most relevant insights. As Davies (2008) states in interviewing the interviewee and the researcher often develops knowledge through interaction. For me it allowed for new directions in my

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[4] *Pakeha* is the *Māori* term for New Zealanders of European descent

thinking and for many research participants too it seems as revealed in comments like: Yes, I never thought about it that way but actually that is very true" (Lisa, 2013). However interviews were the most successful tool in the combination with other research methods as that allowed me to get a more complete picture.

Auto ethnography

Another crucial research method for this thesis was auto ethnography. Auto ethnography is a type of self-reflection that examines the personal experiences of the researcher (Marechal, 2010). Self-reflection can be understood as turning back on oneself, an act of self-reference (Davies, 2008). I decided to apply auto ethnography as a research method for two main reasons. First of all the *Te Whare Awhina* staff wanted to hear about my feelings towards the facility as they believed that due to not being in the emotional distress the residents were in I was able to look at the facility with a more critical eye, especially in terms of the improvements that they thought were necessary.

Paradoxically I was in emotional distress already a day after I started my research as I learned that someone close to my family was dying. Therefore I actually felt very much akin to the individuals at *Te Whare Awhina* feeling similar to what they said they felt. This became the second reason why I applied auto ethnography, as my situation seemed very relevant. I never mentioned my situation to others at *Te Whare Awhina*, mostly for the reason that I did not want to completely loose my objectivity. However, I was able to look at the facility for what it was, as for me *Te Whare Awhina* did not have the same relevance in terms of accommodation that it had to the residents. Auto ethnography was also linked to participant observations. Talking in the kitchen in the late evening and listening to the stories of others made me reflect upon my own perceptions and allowed me to observe the behaviour of others simultaneously. Due to my own grief I could really comprehend what patient caregivers were talking about when they told me about their experiences and feelings. In this research context auto ethnography made me an insider and outsider at different dimensions and for that I believe it was a powerful tool in understanding *Te Whare Awhina*, its staff and residents.

Photo ethnography

Figure 1: Impressions captured during fieldwork

The last method I applied within this research context was photo ethnography. *Te Whare Awhina* aims at receiving funding from the Auckland District Health Board (ADHB) to give the facility a 'make over'. However images have never been taken and since none of the ADHB managers had ever been at the facility they simply do not know what the place looks like in its current state. Therefore I decided to take images for *Te Whare Awhina* so that they could utilise these images in their claim for funding. As Davies (2008) says, one of the strengths of photographs is that we assume that they are objective representations. Certainly the problem here is too complex to be just resolved with a few images, but in this context images became supporting arguments for achieving the goal of funding in the applying for financial aid.

Furthermore for the purpose of my thesis photo ethnography was a beneficial method as it allowed me give the reader a visual image*,* a glimpse into the facility of *Te Whare Awhina*, for instance the kitchen/ lounge area, which I will talk more about below. Certainly, as Davies (2008) states, images reflect only a very limited selection of what is visible for someone standing in the same position as where the picture was taken. Images are selected compilations of what the photographer wants the outsider to see and in that they are subjective representations of any given place. Within this thesis I attempt to overcome this issue by contextualising the few pictures utilised and to discuss the circumstances in which the images were taken. However it is important to mention that in this thesis images only support arguments. Photo ethnography is

much more relevant to the outcomes produced for the *Te Whare Awhina* service than for this thesis, which can be noted in the limited number of images portrayed here.

Limitations of methods

Within this research a number of limitations existed. The most obvious limitation was the narrow time frame; my research was conducted in a two-week period. Therefore the results gathered must be considered as a two-week "snap-shot" of TWA. However staff reassured me that much of my research mirrored the typical *Te Whare Awhina* environment, for example the demographics present at the time seemed representative for the facility.

Furthermore, being a researcher and introducing myself as such gave me a certain outsider position and potentially limited the closeness to my research subjects and the amount of valuable information. However, since I always sat in the kitchen among the residents acting like everyone else, for example by having a 'cuppa' with others and by sharing meals, I believe to have overcome this limitation as far as possible. Another limitation was my being a complete outsider to *Māori* culture reducing my understanding of certain *Te Whare Awhina* concepts and values, because I was relatively new to it. However it might have been advantageous as well, as I was not expected to know about *Māori* Culture the way *Pākehā* are as I was a foreigner. In this I applied an etic approach rather than an emic approach. The emic approach on the one hand analyses how local people think, perceive and structure the world, their rules for behavior and their decision-making processes (Kottak, 2006). The etic approach on the other realizes that members of a culture are too involved in their culture to analyse it objectively (Kottak, 2006). In the etic approach the researcher stresses what he or she considers as significant (Kottak, 2006). In my etic approach I was able to analyse cultural concepts in a relatively objective manner, as I basically knew nothing about it.

Dealing with research participants in crisis and emotional distress was limiting, since there were times when they seemed too stressed and I refrained from engaging them in conversation. It could be argued that I only talked to a certain type of person, the more extroverted, outgoing type. However, the more comfortable the guest got at *Te Whare Awhina* (which is often connected to their length of stay) the more likely they were to talk to others. I overcame this limitation by simply giving informants time, by allowing them to get familiar with the facility and develop trust towards the new environment and me before I approached them.

During the observations many different behaviours, interactions, feelings, smells and sounds often occurred simultaneously and in that I was limited as often there was no time to jot down everything. As Tjora (2006) states this is a major challenge in observations and potentially I missed out on crucial aspects. Furthermore I did not record the interviews I conducted, as I was overly concerned with protecting my research participants. This was a major limitation in my research as I had to write everything down and in that I often was not able to keep up eye contact and I might have 'missed out' on certain bodily gestures, faces and clues. Also, this way many comments might not be revealed here exactly the way they were articulated. I dealt with this limitation the best I could by creating relationships with informants before the interview, to avoid trust barriers and to receive the most relevant information. However as I found this to be a major weakness in my research I would apply voice recording in future research as the benefits far outweigh the concerns I had. This will be discussed more in depth later on in Chapter nine. Doing photo ethnography I had limited abilities to take 'good' pictures. In this context a good picture was a picture that could supports *Te Whare Awhina's* arguments for funding in their applications. Here, to counterbalance "bad pictures", I discuss images in context and back up these discussions with accounts from the guests and staff.

CHAPTER 6- What is *Te Whare Awhina?*

Within this chapter *Te Whare Awhina* as a service will be discussed as being more than merely an accommodation provider. This is crucial as it helps to identify the importance *Te Whare Awhina* holds to residents, patients and the broader community. Furthermore this chapter supports the argument for the existence and maintenance of places like *Te Whare Awhina* due to their unique function in society.

Residents at *Te Whare Awhina* are most often in some sort of crisis, many times being in limbo, not knowing if they will leave the facility with or without their family member in hospital. For example, one research informant arrived at the *Whare* as her son was involved in a serious car accident, at first his situation was critical and it was not clear if he would recover or not (Interview, Sally, 2013). Also one staff member informed me that when patients are located on Ward 82 (the Intensive Care Unit) then every staff member knows to put extra effort into looking after the associated patient caregivers as here more then on any other ward the patients might not recover (personal communication, Christine, 2013). Therefore I suggest that *Te Whare Awhina* is what Foucault (1967) considers a 'crisis heterotopia' as this is a place reserved for individuals who are in a state of crisis (Foucault, 1967). In this thesis a crisis is considered as what the 'Medical Dictionary' defines to be a medical crisis, "*an emotionally stressful event or a traumatic change in one's life*" (Houghton Mifflin Company, 2007). *Te Whare Awhina* has a unique function as a caregiver accommodation service in Auckland. Also the Ronald Mc Donald House (n.d.) is a caregiver accommodation facility within the region, however only for parents of hospitalised children. The Child Cancer Foundation (2010) as well offers accommodation for caregivers, but only for those of cancer patients that are underage. *Te Whare Awhina* is the only service that specialises in accommodating and supporting caregivers of adult patients and in that it has a unique role in the Auckland Region. This is in agreement with Foucault (1967) who states that heterotopias have a precise function and exist within every culture.

In the case of *Te Whare Awhina* the recent development of patient-family centred care and the growing understanding of western society that *whānau* is very important in

the recovery process of a patient brought this heterotopia into existence. Foucault (1967) shares this understanding as he states that when society changes the function of heterotopias can change. All respondents agreed that closeness and easy access to the Auckland Hospital were the most valuable feature of *Te Whare Awhina* as it enabled them to support their patient continuously in the hospital. One respondent stated that she felt calm knowing that she could see her husband at nighttime if it was necessary (Interview, Zoe, 2013). Lisa mentioned that *Te Whare Awhina* allowed her to see her son throughout the whole day and she believed this was the most important quality attached to the service as it allowed her to assist with washing him, bringing him food and clothing (Interview, Lisa, 2013). Stefanie considered the facility to be valuable simply because it was available and for her that was what made the place special (Interview, Stefanie, 2013). The *kaupapa,* (the *Māori* term for policy or agenda) of *Te Whare Awhina* goes along the lines that supporting the wellbeing of the residents is a main aim of the service (Staff interview, 2012). Most patient caregivers agreed with that statement that *Te Whare Awhina* functioned as a supporting agent for them and their patients during their crisis.

> "Without it (*Te Whare Awhina*) I would have gone crazy in some motel room. There are always people here to support you, who you can talk to. " (Tom, 2013)

Like in the quote above some informants believed that the care and support *Te Whare Awhina* offered to the residents helped them enormously in coping with their situation. The *Whare* is a place that makes residents feel like they are at home, despite the fact that they are not; all residents are travellers living at least 150km away from Auckland. Also individuals feel a lot of gratitude for being able to stay at *Te Whare Awhina* as it offers them support and shelter while it simultaneously reminds them of the crisis they are in (Group interview, 2013). These contrasting ideas that usually do not exist in one place can be explained with Foucault (1967), as heterotopias are capable of bringing together different spaces that are usually incompatible in one space. In that *Te Whare Awhina*, as much as other heterotopias, is a place that exists "*outside of all places, even though it may be possible to indicate their location in reality*" (Foucault, 1967, p.1).

The passing of time is often perceived differently at the *Whare* than in the everyday life. Tom mentioned that time seemed to decelerate when there was a major operation on his cousin while time seemed to 'fly by' when he had the chance to take the patient out of the hospital for a day or two (Interview, Tom, 2013). Lisa stated that when her son made progress, such as starting to walk again, then time felt as if it passed by quicker. However when her son was lying in bed and there seemed to be a phase of stagnation in the recovery process then time seemed to slow down (Interview, Lisa, 2013). In that way, the perception of how fast time proceeds during the stay at *Te Whare Awhina* is highly dependant on the wellbeing of the patient in hospital. This is an understanding that can be explained with Foucault (1967) as he explains that heterotopias are linked to time.

Order at *Te Whare Awhina* is created through strict rules and regulations that must be followed by all residents. For instance staff member Christine asked a young girl not to wear her red bandana as it was an indication that she was part of a violent gang existing in New Zealand (Field diary, 2013). Christine mentioned that it is crucial to prohibit clothing that potentially could be associated with a certain gang and hence with related ideas (for instance of racism) to avoid unrest and discomfort for others. For *Te Whare Awhina* it is very important to not support this understanding as it goes against the values of the service and to keep order inside the place (personal communication, Christine, 2013). Also the liquor ban within the facility and the prohibition of bringing visitors into the facility are rules that have to be strictly followed. In terms of heterotopias this means an order is created that does not exist in this constellation somewhere else (Foucault, 1967).

> "I came to this place where love surrounds, encircles and embraces all who have the code to *Te Whare Awhina*" (*Whānau* thoughts, reflections and recipes, 2012).

Te Whare Awhina is located in a separate building and with the outside walls this place is isolated from the external world and in knowing the door code of the facility a patient caregiver becomes an insider of the place as it offers them the freedom to independently enter and exit the service. Simmel (1994) offers a similar understanding for when someone steps through a door as once you step through the door you enter a separate space that is unified and divided from the rest of the world.

Therefore it is like Foucault (1967) states - you can enter and exit a heterotopia; you are either inside or outside of if and, in that, heterotopias sustain systems of opening and closing.

The inside space of *Te Whare Awhina*

Within this section the focus is on the inside space of *Te Whare Awhina*. Understanding how the space within *Te Whare Awhina* is constructed is important, as it is the foundation to understanding why people feel the way they do in this heterotopia and hence it is an important piece in the puzzle of grasping the indispensible quality that seems to be attached to *Te Whare Awhina*. Within this thesis, space is understood as a social product developed through human intentions (Lefebvre, 1991). Space is a tool to grasping the phenomenon of these caregiver accommodations and it is mentioned that space can create an understanding of a certain community (Lefebvre, 1991).

> "I was lost out there and then I came in here and the smile of the staff made me feel comfortable immediately" (Ara, 2013).

This is an example of how the positive attitude of the staff influenced the way the space was perceived by a resident as their friendly smile made her feel comfortable, she felt welcomed and cared for. The way we perceive a certain space is highly influenced by the behaviour of the people within it. Later on in chapter three I will discuss social interaction and its impacts more in depth. Now I will put emphasis on the physical space to allow the reader to gain an idea of *Te Whare Awhina* 's physical setup.

Ground level, Te Whare Awhina

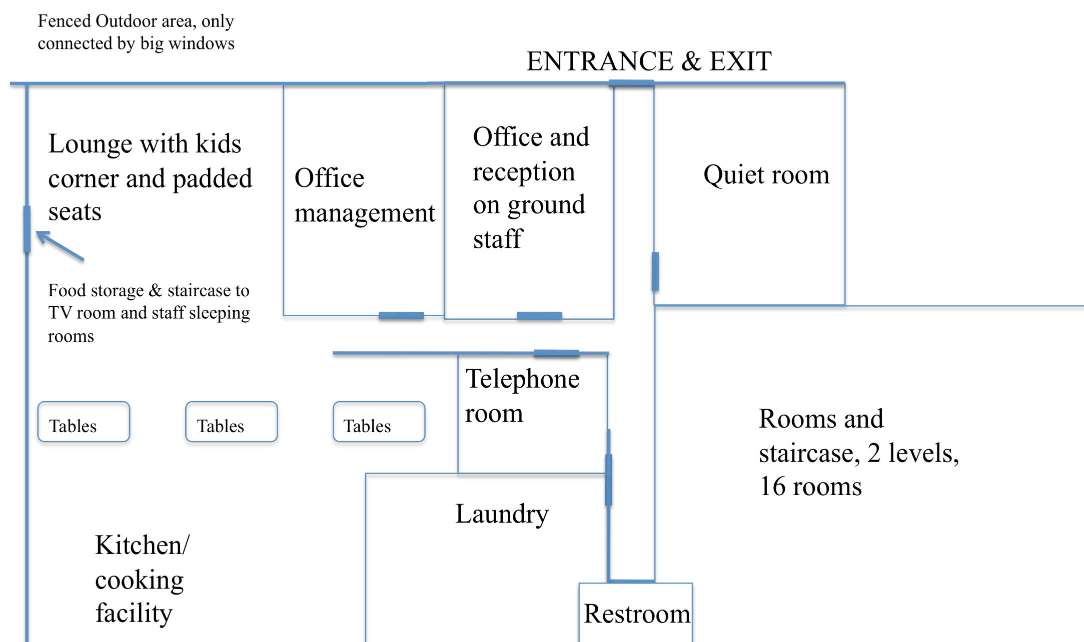

Figure2: Layout of the *Te Whare Awhina* ground level

On the first day of my field studies, I made a sketch of the physical layout of *Te Whare Awhina*. As illustrated in *Figure 1* the ground level portrayed is dominated a large kitchen/lounge area (Field diary, 2013). As illustrated in *Figure 1* the ground level portrayed is dominated by a large kitchen/lounge area. One day, a patient caregiver cooked *Māori* bread for everyone in the kitchen and the next day she cooked it again, teaching a young adult her family recipe (Field diary, 2013). For many days an elderly man heated up ready-made microwave dishes for his dinner at exactly 6.15pm (Field diaries). Another morning a lady making her cup of coffee complained in an angry and desperate manner about the hospital treatment of her son while a staff member and two other residents circled around her, trying to comfort her in her frustration (Field diaries, 2013). Later that day there was only one lady in the kitchen taking her time to carefully clean the fridges from the inside and outside in complete silence; cleaning made the time go by faster and it gave her a feeling of normality she said (Field Diaries, 2013). One evening an elderly couple came into the kitchen/ lounge area- it was only themselves and I. They looked like they were in a lot of stress, they sat and hugged each other, and their body language and facial expressions showed that something very serious must have happened. I offered them to make them a cup of tea, they declined (Field Diaries, 2013). When I returned the

next morning I got to know that their daughter did not survive the night after being involved in a car accident. All these examples show that the kitchen area at *Te Whare Awhina* is not just a place to prepare food; it is also a place to communicate, live a feeling of normality, share stories over a cup of tea, comfort one another and sometimes it is just a waiting room filled with apprehension and hope.

From the layout it can be noted that there is also an office and reception area, which all individuals pass when entering into the building. Here residents receive general information regarding their stay, such as details about their rooms. One day a former caregiver shared a cup of tea and some homemade scones with the staff in this room (Field diary, 2013). When residents had private issues then this was often the place to talk about these too (personal communication, Christine, 2013). Also there is telephone room, which allowed residents to contact staff if they were not in the reception room. Pieces of art, often presents from former residents are located here (Field diary, 2013). The quiet room caters to individual needs, offers an isolated space for individuals and *whānau* retreat and is also utilised to celebrate special occasions. Zoe used this room to study for her nursing degree as well (Interview, Zoe, 2013). This room is filled with *Māori* art and emits a certain quietness and peace (Field diary, 2013). At times I sat here to take a break and relax, however during my research this room was not once utilised by residents. One respondent said he did not use this area as when he wanted to be lonely then he went into his private room, if he wanted people around then he went to the kitchen area (Interview, John, 2013).

Within *Te Whare Awhina* there is a laundry area for residents to utilise. The gated outdoor area has no real function especially since there is no appropriate access. Most days this space was only utilised by smokers (Field diary, 2013). One day the daughter of a residents played on the gate, it looked like she tried to catch falling leaves (Field diary, 2013). However it has been discussed as a goal of staff to turn this area into usable outdoor space for residents- with outdoor furniture, a herb garden with a lemon tree and a barbeque area (personal communication, Christine, 2013). The staircases and rooms are located partly on this ground level and the second level mainly serves the purpose of providing rooms for the residents. The physical space at *Te Whare Awhina* is clearly structured, having different rooms with unique functions. I came to conduct most of my research within the kitchen/lounge area as I identified

this area to be the most vivid space, a space where I can observe that individuals and *whānau*s mingle. Approaching individuals regarding my research was easiest here as this environment encouraged communication with others. Here I got to know many stories of residents, like the story of Stefanie. She was an elderly women from Perth, Australia. She and her husband took a holiday on a cruise ship when her 'hubby' (how she referred to him) fell ill. When their cruise ship came into port in Auckland City her husband got rushed into hospital and she followed (Interview, Stefanie, 2013). Suddenly she found herself standing with her suitcases in the Auckland Hospital, being in a city she had only been in once before 30 years ago. She felt lost, but felt blessed when the nurse told her about *Te Whare Awhina* as it took the fear away from her of where to stay (Interview, Stefanie, 2013). In the kitchen/ lounge many personal stories were shared and it was the place informants were most likely to open up to me as the researcher. *Te Whare Awhina* is a heterotopia in which very personal, emotionally stressful and inspirational stories of people are revealed. That can have a positive effect on patient caregivers as often they get to know stories of others that make them feel less isolated due to sharing similar experiences with them (Group interview, 2013). However not only can the space be understood as a crisis heterotopia, but as a gendered and a *Māori* space and this is discussed below.

Te Whare Awhina- a gendered space

Te Whare Awhina is a gendered space, the 'on ground staff'[5] are exclusively female and their job is based on supporting others and providing care which has been discussed by many scholars as traditional employment for women. However the empirical material utilised for this thesis is limited and having merely female on ground staff might have nourished one-sided arguments in the gender discussion

Being on ground staff at *Te Whare Awhina* is what Bloksgaard (2011, p. 6) describes as a "*highly gender-dominated profession*". The reception area is the main workspace of on ground staff, were they deal with room enquiries, deal with check in and

[5] With on ground staff I refer to the staff that deals directly with the residents on a daily basis. They are available to assist Te Whare Awhina residents needs. The two managers usually do not directly interact with guests.

checkouts. Every day staff exchanged relevant information with each other to prepare the next staff member for their shift (Field diary 2013). They dealt with personal issues of the cleaning staff, managed complaints about parking with the security staff and they discussed the wellbeing of patients and patient caregivers with social workers on a daily basis during this research (Field diary, 2013). Multiple times residents came and asked for things like soap, a flannel or a lift to the shopping mall (Field diary, 2013). If the staff could arrange it then they would fulfil these requests that were beyond their job description (personal communication, Megan, 2013). Hamilton (2011) undertakes research on secretaries, which she states to be a female dominated occupation. Day after day these female employees work in the *Same* physical space, with an assigned desk and a routine that includes daily interactions with others (Hamilton, 2011). Hamilton (2011) findings on secretary workers and the values associated with gender can be applied to the *Te Whare Awhina* context as both secretary work and *Te Whare Awhina* on ground work are in many regards very similar.

However it is important to mention that the on ground staff has many more responsibilities outside of their office as they ensure that everything runs smoothly within the *Whare.* During my research one staff member denied the request of a patient caregiver to bring more family members into the *Whare* as there was limited space (Field diary, 2013). The next day another staff member prohibited a girl to smoke in the building (Field diary, 2013). In that both staff members ensured that residents followed the rules of the *Whare*.

The staff offers support and assistance to residents. One staff member hugged an elderly lady and made her a cup of tea, another staff member went to get some soap for a patient caregiver and another one organised a map of the city for residents during this research (Field diary, 2013). The staff cleans the kitchen, all of them filled and emptied the dishwashers and cleaned the tables during this fieldwork (Field diary, 2013). Most residents choose one staff member to be their main person of reference-they will communicate with this staff member the most and a more personal bond often establishes between them (personal communication, staff, 2013). All these job descriptions involve some sort of interaction with others and in that their work is comparable to Hamilton's (2011) research on secretary workers. As Hamilton (2011)

states workers within unchanging physical locations have it easier to develop close relationships with each other, which inspires mutual assistance and often leads to an environment of caring and sharing. As mentioned earlier this is according to Bloksgaard (2011) particularly obvious in occupations traditionally occupied by women. Caring reflects in the way woman conduct their daily work and they put emphasises on enabling others (Hamilton, 2011). For Hamilton (2011) this phenomenon occurs between women in the same hierarchical position of an organisation. Within the case of *Te Whare Awhina* a caring attitude reflects in the way all staff members interact with each other but it also is prominent in the way staff deals with residents.

> "I mostly value the fantastic people who run it, they make you feel like you are family and that they care" (Maria, 2013)

The quote above displays a way staff is perceived that was shared by most research participants. Residents described that they often felt emotionally connected to the staff and that they were very grateful for the way the staff treated them in their crisis.

Hamilton (2011) mentions that sharing work seems to evolve within close caring relationships between individuals in a group and in her research only women described such work experiences. Men traditionally enjoy working alone which is consistent with the likewise traditional understanding of masculinity being rooted in personal success, strength and power (Hamilton, 2011). Women in a traditional workspace are generally more focused on interacting and communicating with others, creating caring relationships and share tasks (Hamilton, 2011). At *Te Whare Awhina* the on ground staff are female and the values residents associate with *Te Whare Awhina* staff, such as the provision of a wrap around care[6] might according to Hamilton be traditionally associated with females. Women often end up in the role of nurturers, regardless of their line of work. They both assume (consciously and unconsciously) and are by others assigned the role of mothers, whether it be as secretary or manager in an office full of men, in a ward as nurse or doctor; and the

[6] Wrap around care here referrs to a type of care were all dimensions of the human needs are addressed- physically and mentally.

maternal role, as we know, is associated with all the traditional traits of caregiving and support (Enevold 2003). Hamilton (2011) states women tend to build caring relationships, which often involve substantial personal efforts to create these relationships. Often this effort is invisible to organisations.

In the case of *Te Whare Awhina* I gained the understanding that personal effort is also connected to personal reward. One staff member stated that creating relationships makes staff feel connected to others and connectedness is of fundamental importance to them as they are from a *Māori* background where connections to everything and everyone are a fundamental value of life (personal communication, staff, 2013). As the *Māori* value system and the western understanding of traditional female roles are comparable it is not clear if certain attributes are gender specific or rather related to *Māori* cultural values. However, this cultural component will be discussed more in depth under the next heading. What is important within this context is that putting personal effort into the creation of relationships is not merely an act of giving. It can simultaneously be an act of receiving personal reward. One staff member stated that supporting the residents and listening to them in their crisis often led to personal connections. In helping the residents she felt like she lived a fulfilled life and it gave her life significance in the greater context (personal communication, staff, 2013). Hence personal efforts to create relationships can at times be more of a self-rewarding behaviour rather than merely gaining work related benefits as suggested by Hamilton (2011).

A mutual understanding seemed to arise out of having the *Some* gender between residents and staff, which contributed to the wellbeing of the residents. Aroha, an elderly *Māori* lady mentioned that she saw a mother figure in the staff and that she associated a major value with this (Personal communication, 2013). When I asked her what made this relationship valuable she mentioned that feeling like a daughter, feeling closeness and belonging were major values of this perceived connection. O'Connor (2008) states that felt attachment is often described as an occurrence in mother-daughter relationships. Also being a female researcher seemed to be an advantage in my research context, as I could identify with the participants' situations, their needs and feelings. I am not saying that a male researcher would not have had the *Same* experience, but females, traditionally consciously and unconsciously, tend

to put more effort into creating a bond and trust.

Further research has to be conducted to understand the nature of male- female interactions at *Te Whare Awhina*. However the space of *Te Whare Awhina* seems to be characterised by so called “traditional” female values and their existence genders the space in these terms. I believe more research should be undertaken that focuses on the relationships between men and women at *Te Whare Awhina* to clarify if certain values are really as much defined by gender as discussed so far. Looking at the empirical material for this thesis there seems to be a certain quality in the services of the staff that is influenced by their gender, however we cannot be certain of this as no research has been undertaken with male on-ground staff (as there is none). In this research context gender can not be discussed without discussing an ethic of care as these dimensions always overlap and the behaviour influenced by these crossing values always intersect.

Understanding space through an ethic of care

Te Whare Awhina is an organisation that is run by *Māori* protocol and *Māori* staff. As Spiller, Erakovic, Henare& Pio (2010, p.1) state an ethic of “*care is at the centre of Māori value system, which calls for humans to be kaitaki, caretakers of the mauri, the life force, in each other and in nature*”. Key concepts of *Māori* society include manaaki, the cultural obligation to welcome and care for visitors (Robinson, 2001). In traditional *Māori* culture the roles of men and women can only be comprehended through understanding the *Māori* world view, “*which acknowledged the natural order of the universe, the interrelationship or whānaungatanga of all living things to one another and to the environments and the overarching principle of balance.”*(Mikaere, 1994, p. 125) In this collective whole both women and men used to be essential parts (Mikaere, 1994). Men and women were a part of the collective and it was therefore a responsibility of everyone to protect and value their particular roles. However in these traditional views there is no hierarchy of sexes (Mikaere, 1994). Traditionally women were not seen as possessions of men but as individuals who kept their own name in marriage and dressed in garments similar to men (Mikaere, 1994). As Mikaere (1994) states before colonisation care giving for children was a task undertaken by the whole *whānau*, however in the enforcement of assimilation to the *Pākehā* model of a nuclear

family *Māori* women lost their independence and became subordinate to their husbands and fathers and became more and more isolated as the primary caregiver at home. *Māori* women nowadays still are largely absent in leadership positions in New Zealand and still they struggle to provide their input into *Māori* matters (Mikaere, 1994).

In providing this information I want to clarify that in *Māori* culture female roles are traditionally very different to what western cultures often understand as traditional female roles. Where a female leadership role in *Māori* society is traditional it is different to what non-*Māori* might associate with traditional female roles. In analysing female roles and an ethics of care I consider these as two domains that come together in the space of *Te Whare Awhina* but that cannot necessarily be understood as naturally complementary. Rather in this thesis I consider them as two dimensions that can be disparate as in *Māori* society an ethic of care is not necessarily defined by gender but by cultural values. Therefore when I discuss gender and *Māori* Culture I refer back to what 'western society' considers as traditional female roles as from this viewpoint female roles and an ethics of care are comparable and I believe most of my readers can relate to this understanding.

As the staff has mentioned to make a visitor feel welcomed and showing them that you care for them is by making them a cup of tea when they first arrive. The cup of tea acts as a welcoming ritual and every newcomer I met underwent this ceremony in the kitchen/ lounge area, allowing them to connect to the staff and adapt to the new environment. When Christine made my cup of tea she wittily said that now I am part of the team and I have the obligation to make cup of teas as well (Field diary, 2013). The *Te Whare Awhina* space cannot be understood without an ethics of care as this space is shaped by these values as well as it is shaped by gender. Throughout my research it became very clear that *Māori* values are in very many ways connected to values western cultures traditionally associated with females as both concentrate on the quality of relationships. All staff members gave me the feeling like they genuinely cared for me and that they want to help me with my research not because they had to but because they liked doing that (Field diary, 2013). My main contact however was Christine during my research, which was coincidental as my research times were most often during her shifts. I feel like I created a bond to Christine, I felt comfortable with

her and felt very looked after by her (Field diary, 2013). I as the researcher also felt this 'motherly' care and the personal relationship that research respondents also described.

Gilligan (1995) states that a feministic ethic of care understands connection as fundamentally important in human life. At *Te Whare Awhina* traditional female roles (from the perspective of a western society) are in alignment with *Māori* values and therefore these dimensions naturally compliment each other. Spiller *et al* (2010) discusses *Māori* businesses inter alia through spiritual wellbeing. An understanding of spiritual customs in *Māori* culture is crucial as it supports an understanding of the quality that seems to be attached to the *Te Whare Awhina* staff and the relationships created between individuals and staff at this accommodation provider.

Spiritual Well-being

Appreciating the spiritual life force that inhabits all creation is a crucial understanding in *Māori* culture (Spiller *et al*, 2010). *Mauri* is a life force that puts life and uniqueness into every form of creation and inhabits and connects every form of existence (Marsden, 2003). As everything and everyone is connected through Mauri, unity is at the heart of the *Māori* spiritual understanding. Therefore humans belong to all of creation, not only to each other (Williams, 2004). In *Māori* value systems connectedness is an organising principle of the universe and wellbeing can only be achieved through it (Spiller *et al*, 2010). "*In serving others, one is serving one's extended self, and self actualization occurs in relationship*" (Spiller *et al*, 2010). At *Te Whare Awhina* this might explain why staff give as much of themselves as they do. For example one day, a staff member took out residents to a local shopping mall to look for souvenirs. Another day staff went to the supermarket to buy soap for a resident. At times staff takes residents to their local marae[7] if they are enthusiastic about getting to know *Māori* Culture. This happens whenever there is time and the staff has no obligation to do these kind of activities. However in the staff interview

[7] The *marae* is a place of coming together where the culture is celebrated, Te Reo is spoken, families occasions are celebrated. Maraes provide shelter and important ceremonies are performed there, for example the welcoming of visitors or fare welling of the dead.

we found that the staff members enjoyed taking residents out, as they enjoy seeing residents relax for a while and it made staff feel good (Staff interview, 2013). The performance of care at *Te Whare Awhina* can be understood as a spiritual contribution and as explained by Spiller et al (2010) in *Māori* culture the purpose of life is often understood through serving others. Understanding care through connectedness, spiritual values and a female ethic of care allows the outsider to understand why staff offers such exceptional care beyond their obligations. Therefore relationships between residents and staff at *Te Whare Awhina* have to be understood as mutually beneficial.

CHAPTER 7- INDIVIDUAL EXPERIENCES

Being on a journey- grasping the individual experience

This chapter discusses *Te Whare Awhina* from the perspective of the individual patient caregiver staying at the facility. The findings portrayed here are gathered from the research conducted during an internship last semester as part of this Masters degree and from empirical fieldwork conducted at a later stage.

Individuals perceive their stay at the *Whare* as a journey rather than a destination. When I asked my second research informant what she would describe her stay as, she immediately said " A journey! " as if that was the most obvious fact in the world (Field diary, 2013). What does it mean to be on a journey? During my internship the fieldworker from the research institute and I considered staying at *Te Whare Awhina* as a journey, as there is a before, during and after of staying at the facility. However in my own research I emphasised on understanding what the characteristics of the individual's journey are, how individuals act within their journey and how this is of importance in understanding the quality attached to the *Te Whare Awhina* service. A journey can be defined "*the act of travelling from one place to the other*" or "*a process or course linked to travelling*" (Farlex, 2013, p.1). Residents stated why they perceived their stay like a journey:

> "You are on a journey here, the second you walk in, everyday is a different day. Everything can change any minute. I was only supposed to be here a couple of days but that changed and it was quite a struggle but being here made it easier. In every journey there is always a twist and a turn" (Tom, 2013).

> "For me being here is a journey because being here is not something I do every day. You go a different path from what you usually do. Lots of changes happen in that time" (Lisa, 2013).

> "It's a journey being here, a learning journey. You learn a lot if you are out of your comfort zone of your own home" (Zoe, 2013).

As described in the quotes above for residents, staying at the *Whare* was a journey due to the unpredictability of every new day, the challenges that arise spontaneously and the learning experiences gathered. For many residents it would have been a financial burden to stay at a common accommodation and hence they were relieved that *Te Whare Awhina* costs were very small. Also acknowledging that their

experience is different to their everyday life at home makes staying at the facility a journey. Individuals are in a state of crisis when they arrive at the facility due to the experiences they go through with their loved one in hospital. What does it mean to be in a crisis? According to Caplan (1964) individuals in a non-crisis sustain an emotional balance in which stress is coped with by habitual problem solving skills. Individuals may experience a crisis when they are not able to use their coping abilities to deal with stress (Caplan, 1964). Hence a crisis may be defined as an "*imbalance between the perceived difficulty and significance of a threatening situation and the coping resources available to an individual*" (Cohen *et al*, 1983, p. 14). At times a journey and a crisis can be understood in similar ways as they are interrelated, at least in the case of *Te Whare Awhina*. As Caplan (1964) discusses different stages in a crisis response going through different emotional stages has also been discussed within the context of the individual's journeys.

Centre, periphery and the human need to belong

What I have gathered from this fieldwork is that individuals leave their home, their centre and point of reference to enter an often completely new place, a place of the unknown and foreignness.

> "I have been in Auckland around 30 years ago, but I don't know anything about the city..." (Stefanie, 2013).

The quote above was taken from the story of Stefanie, I introduced her story earlier on as she was the elderly lady coming from a cruise ship from Australia, with her husband who suddenly fell ill and got rushed into hospital as soon as the ship was secured in the harbour. However this quote and Stefanie's story shows how unfamiliar some residents are with their new environment. Travelling to Auckland is a very stressful, emotionally overwhelming and confusing time for patient caregivers, as their family member is often critically ill or injured. Some residents had time to prepare for their trip to Auckland; others arrive with no belongings at all. Stefanie had her suitcases with her, however Zoe for instance was with her husband on a motorbike tour when he had the accident and they both got flown with the emergency helicopter into the Auckland Hospital. She had nothing but the clothes she was wearing with her (Interview, Zoe, 2013). Residents often identified the costs associated with other

forms of accommodation as a major burden. Carolin especially was grateful for having free accommodation as otherwise she would have stayed in the car due to not being able to afford other accommodation (Interview, Carolin, 2013). Many people of *Māori* or Pacifica descent at the Auckland Hospital were often concerned with finding accommodation for numerous family members to support the patient. One day a young *Māori* girl was cooking lunch for her *Whānau* who travelled to Auckland every day to see their family member in hospital (Field diary, 2013). When I asked her why they did that she stated that unfortunately she had found no accommodation for them but for her and her extended family it was crucial to spend every day with her sick aunt in hospital and therefore five people drove two hours daily to come to the hospital (Field diary, 2013). This example clarifies that even before arriving at *Te Whare Awhina* people are confronted with a complex variety of issues that make their travel experience even more stressful than they already are. However a crucial finding within this research is that once residents arrived at the *Whare* they soon develop a sense of belonging, considering *Te Whare Awhina* their home away from home. Christine stated that generally you notice after the first 15 minutes how residents relax and feel comfortable (personal communication, 2013). In this the former periphery becomes a new centre. *Te Whare Awhina* is a geographical centre as the building itself provides shelter and safety for the individual. Furthermore it makes them feel connected and reassured. Promoting *Te Whare Awhina* as geographical centre is important as it reflects upon perceived feelings of belonging and stresses the value it holds as a home away from home.

Much research on belonging in connection to perceived feelings of home has been undertaken and the key message most often is that belonging is a basic human need, as is shelter and food (Pitonyak, 2010). At *Te Whare Awhina* belonging is created through the feeling of being part of a community. Geographical space becomes meaningful when we belong to a community as in some ways it belongs to us (Williams, 2009). "*If a person feels inside a place, he or she is here rather than there, safe rather than threatened, enclosed rather than exposed, at ease rather than stressed*" (Williams, 2009). As residents have agreed at the facility they can relax and others that were strangers before become *whānau*. In chapter three I will discuss social belonging more in depth. For now it is important to recognise that a feeling of

belonging is a main quality that *Te Whare Awhina* holds for its residents. Within this context it is important to mention that more than half of the residents stated that the state the facility was something they affiliated with home and hence considered it as positive.

> "It' s a very home like feeling here, it' s not flash, not run down, it' s just comfortable" (Rebecca, 2013).
>
> "This place isn' t flash, but comfortable. I don' t feel like I need to worry about breaking something, that' s great" (*Māori* women, 2013)

Staff considered renovations as a very important aspect in terms of improving the facility. However most residents feel very comfortable with the way it is. Hence even though many agreed that a new coat of paint would be beneficial for the facility, most did not consider this as a major issue. Many residents associated the facility with feelings of home, which implies feelings of belonging, and therefore improving the state of the facility is not as important to guests as suggested by staff. On the opposite it is a quality of the facility for many residents as it nourishes feelings of home and hence it is crucial in any attempts of renovation and improvement to not loose this value.

However staff member Megan mentioned that it is important to make people understand that the facility is only a temporary home, as many residents would otherwise not leave the facility after their patient recovery. For example, Tom who was a former resident visiting *Te Whare Awhina* during my research had been a resident at the service for four months (Interview, Tom, 2013). He stated that he felt very attached to the place and as he had lost his job and house at home due to the excessive amount of time he spend with care giving his patient he felt completely lost outside of *Te Whare Awhina* (Interview, Tom, 2013). Staff ensures that residents always understand that the facility only acts temporarily as a centre and place of belonging for the individuals and serves merely the function of supporting the patient caregiver and indirectly the patient until they get discharged from the Auckland Hospital. For Tom leaving the facility was still difficult, as he knew that back home he would be confronted with major financial issues (Interview, Tom, 2013). Centeredness and the feeling of belonging can cause issues that continuously need to

be addressed to protect the wellbeing of the patient caregivers during and after their stay at the facility.

Te Whare Awhina is on the Auckland Hospital grounds. Most residents consider everything beyond the borders of these grounds a periphery, as it is an unknown and unfamiliar environment. Some residents mentioned that they feel unsafe and frightened to cross the borders to the outside world.

> "I' m scared to know what' s beyond this fence" (Stefanie, 2013)

Yet others see the outside world as a place to rejuvenate and get away from it all. Residents stated that they went for walks and to the Domain (the biggest park in Auckland, also in close proximity to the hospital) to to relax; some also stated that they went shopping and looking for souvenirs to get a break from the hospital routine. The length of stay seemed to be connected to how much time residents spend outside of the Auckland Hospital grounds. Reasons for this were most often that residents felt bored and needed distraction in the long waiting hours between operations of patients and visiting hours.

> " I went to the museum [...], to K road and checked out the 2 Dollar shop there [...] I got my eyebrows done and went to second hand shops. I do that to pass time, have a look around and get out" (Lisa, 2013)

Eating out and going for walks were the most commonly undertaken activities outside of the Auckland Hospital grounds.

Navigating between different spaces

From the research it became clear that during their stay at *Te Whare Awhina* residents adapted to new environments and navigated between them. One respondent for instance stated that it was a new experience for her to share the kitchen and bathrooms with others but that she enjoyed that everyone was considerate for one another (Interview, Zoe, 2013). Löfgren (2008) discusses individuals in borderlands and how in moving between both sides of the border they develop skills for both worlds. In many ways residents at *Te Whare Awhina* can be compared to these people as they constantly cross borders between different environments. Residents move between their actual home, their temporary home *Te Whare Awhina*, the Auckland Hospital

and the broader Auckland City. In that residents have to learn to deal with different environments. One resident in particular talked about moving between the spheres of *Te Whare Awhina* the Auckland Hospital and the area beyond the hospital grounds.

> "When you go into the hospital it starts all over again. You go there and you are all down again because your are confronted with the person again you know so differently [...] that really hurts [...] being at the *Whare* and going o the park lifts my spirits again" (Michelle, 2013).

From this example it became clear how moving between different spaces generates different emotions, feelings and challenges. This respondent considers the hospital and seeing her patient as a very stressful and emotionally painful experience, whereas other spaces such as the park and *Te Whare Awhina* were regarded as positive and supportive. Understanding the different benefits and challenges different spaces hold are crucial to understand the aspects that support patient wellbeing. For instance, the Auckland Domain is a place for them to relax and the shopping mall a place to get a way from it all. Further research should put more emphasise on other potential spaces that support the wellbeing of patient caregivers, such as local churches to grasp the special value different spaces hold in a crisis and to then be able to inform new residents about the availability of certain places in the area. The quote above also portrays the 'emotional rollercoaster' individuals experience on a daily basis. Every day is different, like on a journey- you never know what the next day will bring, as most residents agreed.

However in moving between different spaces and crossing different borders of *insiderness* and *outsiderness* individuals learn new skills to adapt to new environments. Some informants within this research mentioned that they were less shy at the *Whare* and found it easier than usual to open up to other individuals. Caplan (1964) argues that a crisis is also a transitional period that can lead to personal growth. Growth might arise out of learning new coping capabilities (Caplan, 1964). I had the opportunity to talk to one informant who came to visit the facility four months after he had stayed there.

> "This place has changed me, I am happier now. I am happy to communicate to people and I am happy to sit in a group. Before I didn' t

> have the confidence but now I go up to people and chat. I guess I am a happier person now" (Tom, 2013).

This example shows that staying at *Te Whare Awhina* has given Tom new skills that he has taken with him after his stay. This provides a brief insight into the long-term impacts *Te Whare Awhina* has had on this resident. More research has to be conducted to examine the long-term effects this place has on residents to understand the value of *Te Whare Awhina* that seems to go beyond the time spend at the facility, potentially this place has an even greater impact on residents than discussed until now.

While staying at the *Whare* all residents have to follow strict rules. For example, consuming alcohol is strictly prohibited, the kitchen area is closed during certain times of the day, guests are obliged to be silent in the hallways to the rooms.

Figure 3: Sign located in staircase before entering hallway to residents' rooms

Residents cannot bring in visitors to the *Whare* as it might make other residents feel uncomfortable. Also no more than three members of a *whānau* can stay at the facility due to capacity issues. Most residents said that it was not an issue for them to follow these rules. For instance Olivia mentioned that she struggled with certain rules, such as not bringing in visitors to the facility however she understood that it was for the common good and therefore obeyed these rules. The findings also revealed that through these rules some residents gained a greater understanding of what it meant to be part of a group. For example Olivia also stated that being at the *Whare* has taught her that following rules is not just about prohibitions but also it is a way of showing respect for others. Hence rules and regulations nurture a positive communal life while they can influence the individual's considerations of others.

As mentioned earlier *Te Whare Awhina* is recognised as a home by many patient caregivers. Douglas (1991) states that a home is not just a building of four walls but also an internal order, with habits, rules and rhythms. Therefore rules and regulations at *Te Whare Awhina* support the feelings of home and belonging. Furthermore Ehn and Löfgren (2010, p. 84) state, "*A home is above all a web of routines*". The next section introduces some daily routines and analyses their significance for the individual.

Routines

Routines can support the perceived feelings of home. The daily life at *Te Whare Awhina* rotates around the visiting hours of the hospital; most wards allow visitors from 11am to 1pm and 3pm to 8pm (Healthpoint Limited, 2013). Zoe for instance mentioned that she organised her day around the doctors and physiotherapy appointments her husband in hospital had and around the visiting hours (Interview, 2013). During the stay of their patient in hospital many *Te Whare Awhina* residents described a daily routine they maintained during that time. Within this research as everyone started to describe their typical day at the *Whare* by them waking up. In a chronological order habits were discussed, ending with the individual going to bed. This goes along the lines of Ehn and Löfgren (2010) who state if people are asked about their routines they will often start by describing morning habits. From the interviews it can be summarised that most informants woke up before 9am, had breakfast and then took care of personal matters (such as doing laundry, preparing lunch or cleaning their room). Many then went up to the wards to see their patient until approximately one o'clock in the afternoon. Within the Auckland Hospital resting hours some residents then came back to the facility to have lunch and have a rest themselves. Others used this time to explore the Auckland City and its attractions, go for walks or do food shopping. This was the time many considered as a time to relax, rest, a time to get out and rejuvenate. At around 3 to 4pm many residents went back to the hospital to stay with their patient until approximately 8pm. Most people then had dinner at the *Whare*; many shared their dinner, experiences and stories with others during that time. (Interviews with residents, 2013).

Through conducting observations I realised that morning and late evening times where the peek times of social interaction at *Te Whare Awhina*. It was also the time many residents watched television in the TV room and many contacted their *whānau* and friends outside of Auckland during that period. Two young adults stated that they would have liked having an available internet connection within the building, as in the evening they would have liked to check Facebook and contact their *whānau* and friends on this and other social network (Interview, Sariah and Brian, 2013). From the interviews it can be summarised that by about 10 to 12pm most residents went to their rooms, some said they read and others just went straight to bed. Many residents described this sequence of routines, however many factors challenged these routines such as a certain operation schedules of the patient in hospital.

Not the difference that exist between the routines of different individuals are of main interest here but the power a routine holds. As one resident said:

> " Routines help you stay sane" (Tom, 2013).

Hence routines are also a coping strategy to deal with the crisis residents go through. At Te A*Whare* Awhina for instance Tom baked on a regular basis, as he was a chef in his 'normal' life (Intercview, 2013). Ara cleaned the kitchen daily as she considered herself house-proud and wanted this place to be as spotless as her home (Interview, 2013). Ehn and Löfgren (2010) state that routines are helpful tools in organising time, they are not merely survival techniques but also create a cultural field of tension. In extreme situations of crisis people try to reconstruct as much as possible of normal life (Ehn& Löfgren, 2010). Routines can make people feel safe and comfortable and they leave space for other things (Ehn& Löfgren, 2010). Some residents mentioned it allowed them to have some time to manage their own stress.

> "Routines allow you to have a rest" (Lisa, 2013).

Lisa also stated that she believed having a healthy eating and sleeping routine was very beneficial for her physical and emotional wellbeing (interview, 2013). Routines can be considered as one mechanism that aids as a tool of managing ones own stress and hence allows residents to be better supporters for their loved one in hospital. Routines can hence also have positive influences on the patient recovery process. However as Foster *et al* (2012) state having the responsibilities associated with

caregiving is highly demanding, often it leads to social isolation and the loss of financial income due to the amount of time spent with the patient. The health and wellbeing of the patient caregiver may suffer and a sense of burden and depression may remain after the injury of the patient. As mentioned earlier for instance, Tom lost his home and employment due to the excessive amount he spent caregiving his patient. According to him going back home was like "drowning in a black hole" (Interview, Tom, 2013). It is suggested to offer some sort of support to patient caregivers after they leave *Te Whare Awhina,* especially those who spend months and even years caregiving their patients .

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CHAPTER 8- SOCIAL INTERACTIONS

Social relationships and feelings of belonging

Within this chapter feelings of belonging that were most often a result of social relationships are discussed. All research participants valued the *Te Whare Awhina* service mostly for this human element and therefore it will be elaborated upon in depth in this chapter. Social relationships discussed here are these occurring between residents and between residents and staff. In Chapter two I talked about belonging through feelings of home and centeredness. Within this chapter belonging is analysed within the context of informal settings. It will also discussed in relation to staff, through competence and professional care. Furthermore belonging through shared experiences, through understanding, learning and through a shared cultural identity will be reflected upon.

Social interaction is perceived as extremely valuable because it nourishes the feelings of belonging through being part of the *Te Whare Awhina* community, in which goods are shared and differences obliterate through being in a similar state of crisis. The following quote reflects the overall view of research participants.

> "I appreciate this place, because we are all here for the some reasons, you don' t feel lonely, you can chat and communicate with others" (Vicky, 2013).

The quality of *Te Whare Awhina* is very much defined by the values placed on feelings of belonging that are a result of the social interaction with others. Social interaction are to a great extend pre programmed within human beings as a result of natural selection and cultural norms (Argyle, 1957). Some residents staying at *Te Whare Awhina* feel socially isolated from friends and family due to being away from home for often extended time periods. While being at the facility most individuals only have limited contact to loved ones at home as most of their time and effort is put into supporting the patient in hospital. Zoe, for instance, got very emotional when she talked about missing her sister and mother at home (Interview, 2013). As Argyle (1957) states individual unhappiness is most often associated with the breakdown of relationships with other people. While being at *Te Whare Awhina* creating meaningful relationships with others that undergo similar experiences creates a sense of belonging. This is crucial for many individuals as it often compensates for feelings of

isolation from home. Two respondents who were mothers discussed missing their children who they left back home as they did to not want to interrupt their daily routines or stress them (Group interview, 2013).

> "I have a son and he is with my mum, I miss him here but I have to support my brother in hospital now" (Olivia, 2013).

Residents most often put on hold vivid life's back home to support their special patient. It is the perceived feeling of belonging that is brought into being by social interactions, a need embedded within us that make the stay of residents much easier. The following subchapters deal more in depth with what this research has shown about how feelings of belonging evolve at *Te Whare Awhina*. Within this research context social interaction is understood as an act of performance where different individuals obtain certain roles in different situations to achieve certain outcomes (Goffman, 1969). On one hand the value of social interaction lies in the breakdown of performances that traditionally occur in dealing with others, which make interpersonal differences less prominent. For example, one resident stated that occupation and stutues did not matter in the *Whare* and to her this equality gave the service a special quality (Interview, Stefanie, 2013). On the other hand the value of social interaction can lie in the professional performance of a certain role by an individual that in return creates trust relationships, nurtures communication and makes individuals feel that they belong. For example one resident mentioned how another resident was like a teacher to her at one evening, teaching her about the emotional stages she would go through. She believed this helped her a lot in understanding her emotions and dealing with them (Interview, Candy, 2013).

Belonging occurring through informal settings and the buoyant attitude of staff

This following image portrays the kitchen/lounge area, which I discussed earlier on to be the main place of fieldwork for this thesis as it was identified to be the 'hotspot' of social interaction. Even though space was discussed before in this thesis I return to it here only to explain it in connection to belonging.

Behind this image is an extended kitchen area, with kitchen equipments, such as fridges and sinks. Within the image a table with three residents is shown. Tables can also be found on the left and right of these individuals.

Figure 4: Kitchen/lounge area of *Te Whare Awhina*

In comparing this image with *Figure 2* the complete layout can be understood. The space behind the individuals is the lounge area, which is most often utilised in the evening time. During my research the lounge area in the back mainly functioned as a space to call friends and family back home and to sit with ones own family members. Within the lounge area there is a small children's corner that one four-year-old made use of during my fieldwork. Magazines and books were also available to read in that area. The tables in the kitchen area are the main point for communicating with strangers and non-family members.

The tables are placed in the centre of the room and are the first objects noticeable when entering this space. This space encourages residents to casually sit next to strangers, in fact if having a meal in the kitchen is desired than there is no other option but to sit on these tables. Usual barriers between individuals vanish and sitting next to strangers comes naturally in this setup. Hence the informal setting does not just nourish social interaction, it demands for social interaction. This setup creates an opposite phenomenon to settings in many environments where people come together, such as cafés or hotels. In these others spaces individuals knowing one another cluster around a certain object or within a certain space, hence the temporary space they inhabit most often excludes strangers. At *Te Whare Awhina* social interaction is not defined by who we are familiar with but by the experiences that connect us. Therefore the setup of the kitchen/ lounge area is a crucial condition to allow residents to interact and create feelings of belonging.

> "When I first came [...] I was scared but as soon as I came into the kitchen people asked me to have food with them, we chatted the whole night. From that moment on I felt welcomed and cared for" (Zoe, 2013).

As this example shows a major value of *Te Whare Awhina* is placed on including newcomers to the community. In the case of *Te Whare Awhina* inclusion nourishes feelings of belonging and makes residents feel supported. Individuals who seek alone time can always find retreat in the quiet room. However during my fieldwork all research participants placed a high value on the support they gained from interacting with others. Zoe (2013) for example stated her favourite time within *Te Whare Awhina* was the evening as patient caregivers came together on the kitchen tables to share a cup of tea and their stories (Interview, 2013). The informal setting of the kitchen area therefore is important in making residents interact and hence it nourished feelings of belonging. This is comparable to Halding, Wahl and Heggdal (2010) who discovered that patients in a rehabilitation centre valued the informal setting as it made gatherings pleasant, encouraged engagement and hence generated feelings of belonging.

Another aspect that fostered feeling of belonging was the buoyant attitude of the staff. Here especially a friendly smile from staff is often described as the first impression residents get when arriving at the facility, which made them feel welcomed. The gentle tone of voice in conversations with the staff made traditional roles associated with health care providers and residents less protruding and therefore encouraged participation in communication and in that encouraged feelings of belonging.

Belonging as a result of professional care

The staff fosters trust and relationships with individuals through performing professional health care roles that make the individual feel welcomed and cared for. Residents said that staff is experienced, skilled and highly attuned to their needs (Group interview, 2013). Zoe appreciates the staff doing the 'little' things, such as making a cup of tea or a bowl of soup (interview, 2013). For others it is about providing them with the space they need, or someone to talk to (Group interview, 2013).

In performing their role as supporters and health care providers the staff supports the resident. Relationships are defined in the way staff performs and behaves with residents. Staff, intentionally or unintentionally, employ a certain professional caregiver behaviour that has positive effects on the residents. Staff has mentioned that they have days they feel exhausted and tired, however they consider it fundamentally important to not show this side to the residents as they are dependant on the support and care from them (personal communication, Christine, 2013). Professional care was displayed through the ways of communication, through the constant availability and accessibility of staff and the prompt respond to any issues the residents had. For instance in one case a patient caregiver complained about not having shower gel in her room, the staff member on duty promptly went to the shops and got her these items- even though these were not commonly provided goods (Field diary, 2013). Research participants made only positive comments about the staff behaviour and the care they received and hence it has to be noted that staff continuously perform professional caregiver roles that made all the research participants feel welcomed and cared for. Staff has furthermore been referred to as *whānau*, which reveals how emotionally attached some residents feel towards staff members.

> "When I am here I feel like being back with mum, that's how I feel about the staff" (Jane, 2013).

This reflects upon the nature of care staff provides and the positive impact it has on residents. However it has also been noted that residents respect staff and oblige to rules and regulations.

> "There is respect between us and the staff and we all look after the place" (Sariah and Ben, 2013).

While staff often seems to perform motherly roles they keep their professionalism in the eye of the residents and are respected in their roles as guardians of the facility. Hence a tremendous quality of *Te Whare Awhina* is in the consistent positive front stage behaviour of staff that creates trust and nurtures social belonging while simultaneously fosters respect.

Belonging evoked through shared experiences and understanding

Social belonging was most often noted within the context of sharing experiences, a shared understanding and learning from others. During crisis individuals have increased desires to get support from others and are more open for interpersonal intervention (Caplan, 1964).

Te Whare Awhina allows the individual to tell others about their experiences.

> "It 's nice here and everybody listens to me and listens to my experiences…" (Rebecca, 2013)

Many residents commented that sharing their stories was a way of relieving stress and dealing with their crisis. Many residents considered talking to be healing, comforting and it supported their wellbeing. Simultaneously listening to the stories and experiences of others was mentioned to be equally important as it made residents feel less isolated with their situation. Communicating with other residents has been discussed of being tremendously helpful in going through this crisis.

> "Here you bump into people and you share feelings, have a cry and talk about things, that really keeps you sane" (Lisa, 2013).

When in a state of crisis it is possible that individuals temporarily forget their naturally performing behaviour and blur out an unperformed exclamation (Goffman, 1969). Therefore the value of sharing experiences can be understood in others accepting the backstage behaviour, authentic self of a resident without being judged or criticised for it. In my observations I saw people act in extreme ways that I considered to be very much of a backstage behaviour. For instance one informant came into the kitchen, bursting into tears and moaning about the critical condition of her patient. Everyone in the room understood this behaviour, listened to her and offered her advice and support. Hence a value of *Te Whare Awhina* lies in the understanding that individuals do not have to act in certain roles; in their state of crisis acting out of character is tolerated. Hence social belonging is nourished as it allows the individual to act naturally and still feel accepted by others.

In the communication between residents it has been noted that when one individual falls out of character then the other one often takes on a certain role. Often this role is

the one of a teacher or advisor. This role is put on to calm and support the individual in need. In this moment an individual in crisis becomes the supporting agent.

> "A stranger will tell me that in a couple of days I will go through this stage and than through this stage and then I get to this stage. I feel like this person understands me and what I am going through and that gives me heads up on what's coming and it prepares me for the next stage" (Lisa, 2013).

As this quote has shown individuals learn from others and feel connected to them due to having a shared understanding. In one situation an individual can share their experiences, not having to hold emotions and feelings back. In another situation this individual becomes the advisor and takes on this role to support another resident. Many research participants have said that in listening to others they can better cope with their own situation, especially since often others are worse off. Some individuals have mentioned that *Te Whare Awhina* has changed them, as they feel more compassionate about others. Others said they felt more humble as listening to the stories of others made them understood that life was not to be taken for granted. Listening to and sharing experiences, learning and teaching, being understood and understanding are all values of the *Te Whare Awhina* service that are precious attributes of the service. It is in these values that the quality of *Te Whare Awhina* can be grasped, the value of social belonging through shared experiences and a shared understanding.

Belonging as a result of a shared cultural identity

Te Whare Awhina is an organisation run under *Māori* protocol. The organisation is especially dependant on this distinction for funding and identity matters. However as mentioned by staff this cultural component does not exclude Non *Māori* but provides a value system that includes everyone. To share and care for others, to create trust and meaningful relationships are the most important aspects within this value system and as staff has mentioned this is a common understanding of harmonic social existence that is not exclusive to *Māori* culture. Hence staff clarified that the *Māori* protocol aids to provide guidelines to provide the best care possible for any resident, of any ethnic background. *Māori* research participants stated that sharing the some cultural identity as the *Te Whare Awhina* service portrays was very important to them.

> "For us the cultural element is really important. The understanding of what we have at home is the some sort of understanding here" (*Māori* ladies, 2013).

Many of these respondents considered the way of living at *Te Whare Awhina* as very similar to their way of living at home. Sharing goods, caring for one another and the value of creating trust relationships was most often affiliated with their community at home and hence nurtured feelings of belonging.

Figure 5: Painting

Figure 7: Artwork

Some respondents especially mentioned their appreciation for the *Māori* art in the facility, mentioning that it makes them feel connected.

Unsurprisingly *Pākehā* did not discuss the some cultural connection, however they valued the wrap around care, relationships and trust as much as *Māori* participants did. Two *Pākehā* informants stated that belonging for them evolved out of new social relationships, during their stay at the facility (Interview, 2013). The *Some* was apparent for the research participants from overseas. For most *Māori* feelings of belongings did not evolve but rather transcend to this new environment closely affiliated with home. For example, Olivia said the community way of living at *Te Whare Awhina* was the *Some* at her home and that made her feel comfortable and familiar with the place.

One aspect that is important to mention within this context is that the way this accommodation provider is portrayed to the outside world potentially makes Non-*Māori* feel unwelcomed. This is for two main reasons. First of all it has been mentioned by two *Pākehā* that when they read the information online about the place they felt that is was exclusively for the *Māori* community (Interview, 2013). As portrayed in *Figure 2* no comments are made on the fact that it caters for *Māori* and Non *Māori* people. Only when the two participants contacted the service they discovered that they also were eligible to stay at the facility (Interview, 2013).

However it takes this extra effort to receive this crucial information. Secondly the name '*Te Whare Awhina*' can cause confusion as only when you speak *Te Reo*[8] can you understand its meaning. All Non *Māori* research participants and two *Māori* participants stated that they did not know the meaning of the name before arriving at the facility. These two aspects especially can make Non *Māori* feel excluded and potentially make them not consider this accommodation in their search for finding a place to stay. Easy solutions are to update the online information available; also it would be beneficial to include a subtitle to the signs of *Te Whare Awhina* to make it feel more inclusive to Non *Māori* people.

[8] Te Reo is the name of the language spoken by *Māori* in New Zealand

CHAPTER 9- ETHICAL CONSIDERATIONS

Lessons learned about ethics…

Within this chapter ethical considerations for conducting research with participants in a state of crisis will be reflected upon. Certainly this fieldwork posed a unique framework in which individuals discussed their experiences within the *Te Whare Awhina* service in their time of need. Ethical consideration might not seem as crucial as the emphasis of this research was on grasping this service rather than on the intimate stories of the residents. However I was confronted with ethical concerns throughout this fieldwork and I believe that many aspects I learned are applicable for other ethnographers who conduct similar research within a similar context. There are three points that I will elaborate upon within this chapter. Firstly, the eagerness of research participants at *Te Whare Awhina* to communicate with me as the researcher will be discussed. Secondly, communication out of the research context will be elaborated upon. Thirdly, the absence of institutional ethical constraints will be discussed and impacts that had on my research will be reflected upon in this chapter.

The eagerness of research participants to communicate

Research participants are extremely eager to share their experiences with you as the researcher. When my fieldwork observations at *Te Whare Awhina* started I was concerned about residents not wanting to share their experiences with me, as I believed they would not be in a mindset to talk about the *Te Whare Awhina* service. However it was most surprising to me that the majority of research participants were very eager to communicate with me. Issues of how to approach individuals soon were replaced with issues of who to talk to first. At times I would speak with one individual while another one set down on the other table waiting for an interview to finish so that they could talk to me. What are the reasons for this behaviour? As mentioned earlier on during crisis individuals have increased desires to get support from others and are more open for interpersonal intervention (Caplan, 1964). What I found during my research is that there are two main reasons why individuals were so willingly participating in my research. Firstly they perceived me as an opportunity to verbally unload their burden and hence it was a strategy of coping with their crisis. Secondly

individuals felt very strongly about *Te Whare Awhina* and felt that by telling me about their positive experiences they would be able to give something back to the service.

Unloading a burden

For some residents I was not necessarily perceived as a researcher but as someone who took the time to listen to them and take them seriously. One time in particular a research participant asked me directly if she could talk to me as she felt she needed someone to talk to. This situation occurred were there was no one else around, when the facility was relatively empty and it was quiet. For me the purpose was to gain information and this individual wanted to share information. What I understood during this fieldwork was that the relationship existing between the research participants and myself was mutually beneficial and not as unilateral as I was concerned at first. When I started this research I was worried that I was exploiting research participants since I was not sure if I could give back anything to the research participants and Hofmann (2004) agrees as in qualitative research it is often an ethical dilemma that personal benefits for the research participants are difficult to define. I made peace with my ethical concerns I had at first as I realised that in the interaction with residents both sides benefited. I applied relational ethics to my research, which are created within a certain situation. It means doing whatever is essential to stay genuine to ones own character, to take responsibility for ones actions and affiliated impacts on others (Ellis, 2007).

I took it very seriously to not put any extra stress on the research participants and therefore for me relational ethics meant to be more than a researcher. I was also someone who was genuinely interested in anything the residents wanted to share, I was genuinely interested in making the individuals feel better and distract them from their crisis for a slight moment. Hofman (2004) argues that especially between a female researcher and a female respondent often a great amount of trust is generated and intimate stories are told. This creates a potentially exploitative situation, as the basis of information is build upon the trust of one woman to another. In the case of *Te Whare Awhina* I felt connected to most participants, respected their situation and

there was an understanding of trust between us. Sometimes that meant not talking about *Te Whare Awhina* but about other aspects that mattered to them, such as their relationship with their loved one in hospital. In this respondents shared intimate stories with me. However my focus in this research was on understanding the *Te Whare Awhina* service and therefore I was able to differentiate between personal matters and research related information. I believe in the *Te Whare Awhina* context research with participants in crisis is only ethical if the researcher takes the time to allow the individual to unload their burden and truly listens to what they have to say. At times this need of the participant to unload a burden should be taken more seriously than the demand for research related information. As a researcher with informants in crisis you have the responsibility to genuinely listen to anything the informants want to share, as it is in this that they gain personal benefits from your research. As Daley (2004, p.33) says "*the researcher as the caregiver and participant as the cared for is the most ethical way to negotiate the complex situations which arise when conducting research with vulnerable [...] people*".

Giving something back

Another reason why residents were so eager to communicate with me as the researcher was that they wanted to give something back to the *Te Whare Awhina* service. Many residents stated that talking to me would hopefully benefit *Te Whare Awhina*. Some residents mentioned that sharing the positive experiences with me was a way for them of giving something back to the facility, as most residents felt deeply grateful for being able to stay at *Te Whare Awhina*.

> "Without this place I would have stayed at the wards or in my car. Wouldn' t know where else to go otherwise, it would have been financially difficult" (Carolin, 2013).

In talking to me most residents felt they could give something back to this house of support and this was a way for many to cope with their own situation. It supported their wellbeing to be able to give something back to the facility as indirectly they hoped that their feedback supported the facility and potentially would help future caregivers in need. In a way it felt that my position as the researcher gifted me with a 'special power'. The power to communicate insights from respondents to the outside

world, which is a power associated with cultural analysts in general. In these situations I felt very aware of my position as an outsider as I was perceived as a professional researcher- being perceived as neither one of the residents nor one of the staff members. It also made me aware of my responsibility that I have as a researcher, the responsibility to genuinely portray the participant's point of view. However the biggest challenge within this context was that some individuals were so grateful for their experiences that it was difficult to elicit information from them regarding necessary improvements and aspects that were not as positive. Getting opinions on the physical appearance and functionality of the facility that were not influenced by feelings of gratitude were challenging however it also showed the value this place possessed to these residents. In creating trust relationships with individuals, often these were established through time, I tried to make individuals feel comfortable with me and unvetted for providing me with negative feedback. However in the end I came to the conclusion that the majority of research participants consider the appearance of the accommodation as relatively trivial as long as it serves the purpose of providing accommodation. The main emphasis is on their patient in hospital and hence everything else is of nominal importance. Only a small minority of participants considered necessary upgrades as crucial to feel more comfortable. Also a minority of participants considered *Te Whare Awhina* in excellent condition compared to their homes, this was most likely related to lower socio economic status. However what staff considered as crucial in making residents feel more comfortable was insignificant to the majority most residents. As a researcher with informants in crisis you therefore have to consider that the crisis often makes everything else become relatively irrelevant. Often gathering information not directly connected to this crisis is therefore challenging and will often only be authentically revealed in relationships that are built on trust and understanding.

Communication outside of the research topic

As mentioned earlier on when I first contacted the Auckland District Health Board and *Te Whare Awhina* it was agreed that no ethical consent had to be granted for my research project as it was aimed at grasping services and not the individual's intimate stories. However what I soon realised was that research respondents in crisis often

have desire to share stories with you about very personal matters. It was argued before that ethical research therefore obliges the researcher to also act as a caregiver. Is it ethical to get involved with personal stories of research participants when no ethical consent regarding this has been signed? Daley (2004) states comprehending to be ethical is complex, not because it is naturally difficult to do good but because what is good is never absolute. I tried to be 'good' by being more than a researcher, by showing empathy and acting like a support person as well as a researcher. However it might be argued that my limited experiences might have lead to unprofessional and unskilled responses. It is true that at times I did not know how to react and I felt unprepared to respond in an appropriate manner, for instance when informants cried. However I always acted along the lines of how I would like to be treated in this kind of situation and I looked at how staff interacted with residents. I came to the conclusion that as long as the researcher shows compassion and empathy for the other than ethical dilemmas in sharing intimate stories are minimised. However researchers conducting fieldwork in a setting with similar circumstances have to understand that over-disclosure will happen and intense emotional responses occur and researchers have to be able to deal with this. As Daley (2012) argues relational ethics are most applicable within these types of research. In the interactions between the researcher and the participant the researcher should also always have the right to make ongoing decisions and grasp finest nuances in the interactions that can alter the 'right' action. Daley (2012) calls these forms of ethics, micro ethics. Researcher should always have the ability to trust their capabilities to make certain decisions with the interactions with participants.

However services like *Te Whare Awhina* should create basic ethical consent forms to provide to all researchers undertaking fieldwork there with general guidelines of how to deal with people for instance when they have an emotional outbreak. This is due to the fact that they hold the knowledge in terms of how to best protect and support individuals in crisis. It gives the researcher the opportunity to professionally respond to individuals in crisis when he/she feels out of their comfort zone and it ensures to the organisation that the researcher is girt for certain reactions and responses.

The absence of institutional ethical constraints

The absence of institutional ethical constraints influenced my way of conducting research and potentially had impacts on my research outcomes. First of all I was extremely careful in my research not to put extra stress on the research participants. This was revealed especially in the nonexistence of recording devices and potentially I might have limited potential research outcomes from participants due to being overly careful during my fieldwork. I explained fully to all research participants that my research was about understanding the indispensible quality of the *Te Whare Awhina* service, that the outcomes would be utilised for my Master thesis and for *Te Whare Awhina* itself. I informed individuals that their information would be kept anonymous and I explained my motivations for undertaking this research. I gained an informed consent from research participants based on a clear understanding of the nature of this research project. It might be argued that in this gained my ethical approval. However an issue for me personally was that I was completely inexperienced with individuals in crisis and hence it was difficult for me to define what is ethical and what is not. The non-existence of recording for instance seemed ethical to me as from my point of view it eliminated extra stress on research. However during the research I realised that research participants benefited from our conversations and at times it supported their personal wellbeing as well. Hence research participants were much less vulnerable than I expected at first.

However if I had organisational ethical constraints I might have been able to refer back to these rather than to my personal perceptions. This might have potentially provided me with more confidence in my research approach and potentially I would have been less concerned with constantly re evaluating what is good and what is bad for the individual and rather focus on the greater good of this research project. As Ellis (2007) argues sometimes the greater good of a research project justifies the potential risks to others. If I would do this research project again I would utilise voice recording as it allows for more complex and accurate information. Also this would have allowed me to analyse the research participants' body language more in depth during my research as possibly valuable, less obvious revelations are in it that support an understanding of the *Te Whare Awhina* service and the quality attached to it.

Fieldworkers who are new to a certain research context should always demand ethical guidelines, as it is difficult to foresee where the research will take the fieldworker and having something to hold on to can only be beneficial for newcomers to a any new field.

CHAPTER 10- Summary and applicability of findings

The most relevant finding in Chapter six ‘What is *Te Whare Awhina?*’ is that *Te Whare Awhina* is a heterotopia, a space influenced by a female ethic of care and the *Māori* value system. *Te Whare Awhina* holds a unique function within society that also is influenced by changes within the society. *Te Whare Awhina* is an accommodation provider that is perceived by its residents as a ‘house of support’. It is due to the understanding that *whānau* are crucial in the recovery progress of their patients that places like *Te Whare Awhina* exist. This facility offered a unique space that allowed residents to relax and rest. Residents identified close proximity to the hospital as the most important value of the service. This facility is a gendered space that is affected and sustained by female values and perceptions. The staff undertook tasks that went beyond their job description, which were explained with a female ethic of care and the *Māori* value system- both dimensions interlinked. Staff gained feelings of personal reward from the care they provide for others. The kitchen/lounge area was revealed to be the main point of social interaction.

The most important finding in Chapter seven ‘Individual experiences’ is that staying at *Te Whare Awhina* was perceived as a journey rather than a fixed stay; especially due to the unpredictability the crisis held. Auckland was a completely unknown place to many residents when they first arrived. The limited costs of staying at the facility were acknowledged as being a major stress relief. *Te Whare Awhina* often was a geographical centre for residents as it provided them with shelter, nurtured the feeling of belonging and providing them with a ‘home away from home’. The perceived feeling of belonging is described as a major quality of *Te Whare Awhina* within this research. These strong attachments to the facility can also cause problems as some residents find it difficult to return to their homes due to unresolved issues there. Some residents felt unsafe and scared to leave *Te Whare Awhina* and enter the Auckland City, while others saw the outside world as a place to rejuvenate and for them it was an opportunity to get away from the hospital. Some research participants visited local attractions, ate out, visited the park and went for walks. Furthermore it was revealed that individuals moved between different environments during their stay at the facility, in this adoption to different places new skills often were acquired, such as

being better communicators. As explained in this chapter the rules and regulations at the facility nurtured mutual respect and supported feelings of home and belonging. Routines were identified as crucial in managing ones own stress levels and indirectly positively influenced the patient recovery process. Within Chapter 8 'Social interaction' belonging was discussed. It was stressed that residents often put vivid lives at home on hold to support their loved one in the hospital. Many felt isolated from friends and family and hence social interaction and feelings of belonging at *Te Whare Awhina* were crucial as they compensated for these relationships, at least to a certain degree. It was discussed that belonging was nurtured through the informal setup of the facility and through the buoyant attitude of staff. Also it was argued that the professional care received, the shared experiences, a shared understanding and a shared cultural identity nourished feelings of belonging.

In Chapter nine 'Ethical considerations' the most significant finding was that research participants at *Te Whare Awhina* were very eager to communicate with me as the researcher. This was explained using the desires of research participants to unload their burden and to share their stories as a strategy to cope with their crisis. Another reason for the eagerness to communicate was that individuals wanted to give something back to the *Te Whare Awhina* service due to the gratitude they felt towards it. Also the potential positive impact their feedback could have on future residents was a strategy for them to deal with their own crisis. Furthermore it was revealed within this chapter that communication outside of the research context was unavoidable and hence it was suggested that ethical guidelines should be obligatory to all researchers conducting fieldwork in this context. Furthermore it was argued that the absence of ethical constraints might have had impacts on the depth of my research outcomes and therefore researchers who are new to any field of research should demand an ethical protocol, as the paths of research can never be foreseen and ethical guidelines can provide the researcher with confidence and peace of mind.

What is the relevance of these findings? Imagine your were a patient caregiver and were looking for an accommodation within Auckland that is in close proximity to the hospital. In your situation you have the time to go on the Internet and search for

'support', 'help', 'accommodation', 'Auckland' (this example was taken from an interview with two informants during this fieldwork). *Te Whare Awhina* does not have its own website, however is mentioned on the top search result, such as the Auckland City Hospital website. You can find information like this:

Accommodation

Te Whare Awhina

This is the accommodation service located on the Auckland City Hospital site operating under Maori tikanga/protocols and is available to whanau/family who meet the entry criteria.

The accommodation is short term and primarily for whanau who live outside the Auckland region and have a family member in hospital.

Whanau who live within the Auckland region who are supporting an acutely ill patient will be considered on a case by case basis.

Patients are not eligible for accommodation.

A small fee may be charged if you are not eligible for a Ministry of Health subsidy.

Bookings are made via a referral from the Auckland DHB service/ward.

Figure 6: *Te Whare Awhina* publically available information

It tells you that *Te Whare Awhina* is an accommodation service run by *Māori* protocol and it provides you with general information on eligibility, fees and booking. However most people will not know what to expect of this accommodation provider before getting there, as many informants have stated. Therefore it is recommended that *Te Whare Awhina* promotes itself as an accommodation provider, that is more than that as it is most valued for the support it offers and the space it provides for the residents. It is crucial that this facility stresses the difference between itself and other accommodation providers such as hotels or motels.

Furthermore promoting staying at caregiver accommodations as a journey rather than a destination conforms more correctly to the individual's experiences. It allows for a more authentic image of what it is like to stay at such a facility. Furthermore it is recommended that residents can be a resource for improving the facility. Even though many informants thought it was a major relief that there was no/limited fee for their

stay, they mentioned that they would like to give something back to *Te Whare Awhina*. Also promoting an organisation with a certain cultural identity might make individuals of this particular culture feel more familiar, however it can make others feel excluded and hence information available to the public has to be clear in terms of eligibility and should to a certain degree reflect upon the whole target audience to correctly appeal to everyone in need.

In terms of conducting ethical research the following findings might be applicable especially by first time researchers who conduct fieldwork in with a similar context. Firstly, every participant has a different story and deals differently with their crisis; a researcher has the responsibility to understand the needs of every participant and act upon those. Secondly, researchers are caregivers as well, which obliges them to genuinely care for the residents, this includes: A genuine interest in the conversation with the resident that goes beyond the research context, a caring response that makes the resident feel supported and cared for and showing compassion and empathy for the informants situation. Thirdly, the researcher needs to be aware that emotional responses and over disclosure will occur, they need to be able to cope with this. Lastly ethical constraints should be taken very seriously as individuals in crisis are vulnerable and institutional ethics can help the researcher to feel less concerned with personal ethics and should therefore always be applied.

CHAPTER 11- Conclusion

This thesis is called '*Caring for the Caregiver'* and discusses the *Te Whare Awhina* service, which is an accommodation provider and supporting agent for caregivers who have *whānau* in the Auckland Hospital in New Zealand. This service is located on the site of the Auckland Hospital grounds and provides temporary accommodation for people living outside of the Auckland Region. Many individuals are in major distress when they first enter this 'House of Support' from being concerned about their patients' wellbeing and often due to being in a completely new environment with unfamiliar faces. Some residents stay only for a night while others stay for months at the facility, depending on the wellbeing and recovery process of the loved one in hospital. This thesis aimed to provide insights that can be utilised by the *Te Whare Awhina* Megangement for funding matters, advertising issues and any other situations where the significance of this service is to be advocated. It was the main aim of my thesis is to define the quality of the *Te Whare Awhina* Service by investigating how the caregiver can be best supported and approached when they are in distress to identify the impact this service has on the residents' wellbeing and hence the effects that has on the wellbeing of their patients.

From this research it can be concluded that the qualities attached to the *Whare* for residents are practical qualities, relational and perceived qualities. Practical qualities are the close proximity and easy access to the hospital, the limited/no costs attached to the service, the provision of beds, towels and food. Furthermore the informal setup of the inner space, the constant availability of staff and having a place available to stay at are practical qualities. Perceived qualities are connected to the individuals understanding of being on a journey rather than a destination during their stay. *Te Whare Awhina* is perceived as a safe haven, where individuals feel welcomed and protected from the 'scary' outside world. *Te Whare Awhina* allows the individual to rejuvenate and take a rest. Individuals move between different places before, during and after their stay at the *Whare* (such as the home, *Te Whare Awhina*, the hospital and the broader Auckland City). Learning new skills, such as becoming better communicators, enhanced team players, learning respect and compassion for others

have been discussed by residents within this context. Hence personal growth is a quality of this service and the research indicates that this service might have long lasting impacts on residents that go far beyond their stay at the *Whare*. *Te Whare Awhina* allows residents to create routines which is another major quality as it allows the individual to cope with their situation, stay ‘sane’ and permits the individual resting and recovering time for themselves.

Relational qualities of *Te Whare Awhina* are attached to the human interaction. These relational qualities are embedded in the relationship with staff and with other residents. The indispensible qualities attached to staff are the kind, motherly, professional care they provide, the emotional support they offer and the effort they put into creating close, trusting relationships with residents. In this a mutual understanding is nourished which often creates and fosters feelings of home and belonging for the individual. Also for *Māori* residents a quality seems to lie in the shared cultural understanding, the shared value system and the shared spiritual understanding between them and the staff. Relational qualities between residents lie within the exchange of experience and stories that make the individual feel connected and fit in. Learning from others and advising other residents have been discussed as tremendously helpful for the residents to cope with their crisis. It is this social interaction that has been described as the most valuable quality attached to the *Te Whare Awhina* service. These relational and perceived qualities reveal why service like *Te Whare Awhina* are so beneficial for the individual and hence it is with the help of these qualities that it can be argued for the significance of such services in any society. Lastly some ethical considerations were revealed in this thesis, as I believed I learned valuable lessons that other researchers should consider when conducting fieldwork in a similar research context. The most important message here was that individuals were very eager to communicate, over-disclosure was unavoidable and imposed ethical challenges for the author.

This research was just a starting point in grasping the *Te Whare Awhina* Service. Further research especially with a political angle would be very beneficial in the case of *Te Whare Awhina* as it is suggested that underlying issues exist that are connected

in some ways to colonisation and to the situation of *Māori* today. Potentially these issues have a broader impact on the internal and external operations of *Te Whare Awhina* than are currently known. Also this research was conducted with mainly woman and hence further research with a majority of male respondents would be beneficial in the case of *Te Whare Awhina* to compare and complete the picture of all those who access this service.

References

List of figures:

Figure 1: Comment on the *Te Whare Awhina*. Citation taken from Ross, T. et al (n.d.). Refer back to reference list.

Figure 2: Impressions gathered and captured during fieldwork. (M. Gottschalk)

Figure 3: Layout of the *Te Whare Awhina* ground level. (M. Gottschalk)

Figure 4: *Te Whare Awhina* publically available information. Screenshot taken from http://www.healthpoint.co.nz/central-auckland/auckland-city-hospital/

Figure 5: Sign located in staircase before entering hallways to residents' rooms. (M. Gottschalk)

Figure 6: Kitchen/lounge area of *Te Whare Awhina*. (M. Gottschalk)

Figure 7: Painting. Located in Lounge area. (M. Gottschalk)

Figure 8: Artwork. Located in quiet room. (M. Gottschalk)

Interviews:

Due to confidentiality issues, names and ages of informants are altered (both for on ground staff and Te Whare Awhina residents)

Ara (2013, March). Interview. Auckland, New Zealand (M. Gottschalk)

Candy (2013, March). Interview. Auckland, New Zealand (M.Gottschalk)

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