UNIVERSITY OF SOUTHAMPTON

FACULTY OF SOCIAL AND HUMAN SCIENCES

School of Education

Personal Best Stories – a Biographical Approach

by

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ABSTRACT

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PERSONAL BEST STORIES – A BIOGRAPHICAL APPROACH

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This study utilises a biographical approach in order to understand the reported individual health and wellbeing outcomes of the Personal Best Volunteering Training Programme for a group of six people. Only candidates, who were not in education or training or were economically inactive, were eligible for the programme. All students on the Personal Best Volunteering Training Programme have experienced social exclusion either through drug and or alcohol addiction or mental illness. Their spoken biographies were collected in the spring of 2012; some six to twelve months after the participants had completed the course. The participant biographies set the research within a social and chronological context. Work by Marmot (2006) maintains that health outcomes are unequally distributed throughout the population and are influenced by personal autonomy and social participation, while the most vulnerable groups in society are recognised as the hardest to reach in terms of health promotion.

This research links the factors which influence health with the recognised benefits of volunteering; which includes enhanced interpersonal skills, increased social networks and the development of personal characteristics (Musick and Wilson 2005). Volunteering research to date has centred on people who already possess extensive personal, social and economic resources. This research demonstrates that socially excluded individuals

experience similar benefits. The findings indicate that the participants reported wide-ranging health and wellbeing benefits, enhanced communication and team working skills, the development of employability skills, improved and extended social networks. However the most significant and pervasive benefit of volunteering for this group of individuals was the development of positive self-concept and enhanced self-esteem. A key recommendation of this study is that socially excluded people should not merely be the recipients of volunteer services but have the opportunity to be prepared and actively involved in the delivery of such services. This work suggests that the PBVTP was a success largely because it was specifically designed to meet the needs of people not in education, training or employment and it recommends that volunteering courses should continue to be offered to socially excluded individuals, however to ensure further success, this study endorses the development and provision of a bespoke course explicitly design for these individuals.

List of Contents

List of Figures

Academic Thesis: Declaration of Authorship

I, Anne Mills declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Personal Best Stories – a Biographical Approach.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

5. I have acknowledged all main sources of help;

6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

7. Either none of this work has been published before submission, or parts of this work have been published.

Signed:

……

Date: 20.02.2014

Acknowledgements.

I would like to acknowledge and thank a number of people who have both inspired and encouraged me in my doctorate journey. Particular thanks go to Dr Gill Clark whose enthusiasm and interest in autobiography and biography persuaded me to delve deeper and learn more about these authentic and exciting methods of data collection. I would also like to pay tribute to Dr Brenda Johnston who provided much needed support and encouragement. Thanks also to Dr John Schulz who kindly accepted the role as my supervisor and offered an extensive array of helpful and constructive comments on all aspects of this thesis. My children Alice and Edward will be delighted to see the completion of this work. Thank you for your support and forbearance during the whole of this writing and research process.

Chapter 1

INTRODUCTION

My interest and awareness of the influence and benefits of volunteering for individuals, organisations and communities has developed in parallel with the experiences I have gained within my professional public health role. For my doctoral research I wanted to gain a deeper knowledge and understanding of volunteering and investigate its uses as a public health tool. Clearly volunteering covers and combines an extensive area and boundaries were required. My key interest focuses on the health benefits of volunteering for people who lack socioeconomic resources and are frequently excluded from society. As a consequence my study explores the effects and experiences of volunteer training on the holistic health and wellbeing of people who have completed the Personal Best Volunteer Training Programme (PBVTP) at a college on the south coast of England. In order to elicit first hand participant experiences and insights, set within a life context, my research utilises biographical method which is illuminated through participant narratives.

This first chapter offers an overview of the study and both a personal and academic rationale for the choice of this study and for the chosen research group. The research is an accumulation and combination of many areas of interest, both personal and professional. The work provides an insight into the commencement and development of my interest in the use of volunteering as a tool to enhance health and wellbeing and acknowledges the current gap in empirical research in this field. This chapter also provides an overview of the subsequent chapters within this study.

EARLY STAGES OF THE RESEARCH

As previously stated this thesis seeks to investigate the use of volunteering as a public health tool. I have worked in the field of public health and health

promotion for many years both as a practitioner and a lecturer. The recent successful bid to host and deliver the 2012 Olympics in UK provided an opportunity for me to study a locally delivered volunteering course directed at individuals not in education, training or employment. The participants' biographies were collected in the spring of 2012 and provided me with the basis for the research and enabled me to study in depth the changes brought about by volunteering for people who have experienced long term drug and alcohol addiction or mental health problems and because of these difficulties are not currently in education, training or employment. My contribution to generating new knowledge and insights concentrates within this area as Musick and Wilson (2003) acknowledge the lack of empirical research on volunteering and this group of people. Enhanced personal and social autonomy are seen as outcomes of volunteering with certain groups; these attributes are also major health promotion aims. As a consequence I was motivated to design a study which combines both elements to allow the exploration of the topic in greater depth.

BACKGROUND TO THE STUDY

Over the past 10 years the UK government has launched many schemes to promote volunteering to groups of people who are not normally involved in volunteering; including; young people not in training, employment or education, long term unemployed, ex-offenders, and those with mental health problems. Development and funding for the Personal Best course is achieved through a multi-agency partnership: partners include national, regional and local government, SkillsActive and The London Organising Committee of the Olympic and Paralympic Games (LOCOG). The Personal Best volunteer training programme is specially designed for long term unemployed and socially excluded people within England; it aims to raise aspirations and create career and employment choices and is seen as an important legacy of the 2012 games. The 120 hour course offers a Level 1 qualification in event volunteering and is advertised as a pre-employment

programme; it incorporates various class room activities and subjects including team working and interpersonal skills, recognising and dealing with emergencies, fire awareness, customer relations, public safety and conflict resolution, with site visits and 20 hours of volunteering. The overall aim of the initiative is to equip the learners, who come from a diverse range of backgrounds, with enhanced confidence and new transferable skills. Personal Best graduates are supported into further learning and employment by programme tutors and all graduates were guaranteed an interview following application to be a Games Maker (certified Games volunteer) at the London 2012 Olympics and Paralympic Games.

The programme was delivered by 50 providers in England; the vast majority of these were based in London, with six providers located in the south west. Courses were offered by a variety of providers including Further Education (FE) colleges. Careful searching revealed that a local FE college on the south coast was offering the Personal Best course. After several investigative telephone calls and visits I chose to concentrate on the course offered at this location and to explore the health and wellbeing outcomes for students who completed the programme. The aim of the course was to provide inclusive opportunities for volunteering at the Olympics and Paralympics. The course ceased to exist following completion of the 2012 Games.

Research Participants

It is appropriate at this stage ‘to meet’ the participants by offering the reader some insight into the background and lives of the participants. These individuals have faced numerous challenges in their lives and these brief summaries of their biographies attempt to capture some of the difficulties and ordeals they have had to live with and manage. Chapter 4 provides more comprehensive versions of these biographies.

Simon

25 year old Simon started using and selling illegal drugs from the age of 14, by 19 he was addicted to a range of life threatening drugs. He attempted suicide several times. For 4 years he tried to break his drug habit and agreed to attend the PBVTP in a treatment centre.

Sally

42 year old Sally became involved with abusing drugs and alcohol as a teenager. She experienced a mental health breakdown after the failure of her second relationship, when her daughters were removed from her care. Following many years of treatment she was encouraged to attend the PBVTP by her support worker.

Gareth

49 year old Gareth started drinking regularly and heavily from the age of 15 and was dependent on alcohol for 20 years. He lost his job and his marriage failed during this period. During treatment Gareth was persuaded to sign up for the PBVTP.

Jacob

39 year old Jacob started drinking boost his confidence in social settings, when he was 15yers old. He also used illegal drugs. He drank heavily and used drugs for 20 years and tried to give up the habit many times. Jacob was invited to the PBVTP during treatment.

Linda

44 year old Linda experienced domestic violence in her first relationship and was forced to live in a refuge with her 3 young children for a long period of

time. She suffered a mental health breakdown following an employment dispute. During treatment Linda was introduced to volunteering and encouraged to undertake the PBVTP.

Stuart

52 year old Stuart started abusing alcohol and drugs from a young age and did not seek help for over 30 years. Although he has attempted to give up alcohol and drugs on many occasions he has had numerous relapses. He was introduced to the PBVTP during treatment.

Academic Rationale

Farrell and Bryant (2009) provide evidence to confirm that voluntary work provides beneficial outcomes not only for those who receive the services of volunteers but also for the volunteer. These benefits include positive health outcomes (Wilkinson 2005), life and work skills (Wilcock 2006), self-confidence development (Bowgett 2006), improved social integration (Institute for Volunteering Research 2004) enhanced civic health and equip people with the skills and knowledge necessary for the world of work (Plagnol and Huppert 2010). Whilst Field's (2003) work, amongst others, suggests that volunteering has the power to offer communities and individuals multiple benefits; including enhanced social and personal resources and the development of both individual and collective social capital. The importance and value of social capital for health, wealth and wellbeing of communities and society is reported in Putnam's (1993) work.

However volunteering is most widely used by people who already have panoply of resources, enabling them to further develop their skills (Musick and Wilson 2003). Work by Attwood *et al*. (2003) records that those most likely to volunteer have a higher socio economic status and more education, while those who are unemployed and therefore have more time on their hands are least likely to volunteer (Strauss 2008). This is supported by

Musick and Wilson (2008) who maintain that married people with higher education and more resources are consistently more likely to engage in volunteer activities. This would suggest that the positive benefits previously highlighted are accrued by people who already have a higher socio economic position and are better educated.

Studies by Marmot (2010) indicate that people living in the most deprived areas of England suffer more ill health and die earlier on average than people living in the most affluent areas, thereby demonstrating a strong social gradient to health. Marmot's (2010, p.10) premise is that 'social and economic differences in health status mirror and are caused by social and economic inequalities in society'. Addressing these inequalities in health has become a major government concern and various policy strategies have been proposed. Over the past 10 years the government has launched many schemes to promote volunteering to groups of people who are not normally involved in volunteering; including; young people not in training employment or education, ex-offenders and those with mental health problems. However there is little research to explore the health and wellbeing benefits of volunteering training and opportunities for people who are not in employment, education or training. This group may often experience a lack of personal confidence and have limited interpersonal communication skills and may not be aware of the personal benefits of volunteering.

The premise for this research is rooted in work undertaken by the World Health Organisation (WHO) (1986, 1988, 1997, 2000, 2005) and Marmot (2006) which suggests that promoting people's health and wellbeing involves helping people and communities to develop the skills and internal personal self-resources necessary to take control of their lives and the factors which influence it. The launch of the Ottawa Charter (WHO 1986) for health promotion, offered a new way of addressing individual, community and population health. It advocates that practitioners involved in promoting health should have the skills and knowledge to enable and empower people to take control of their own health and the factors which influence it. The aim of practitioners should be to facilitate the acquisition and development of

personal and social skills and to aid understanding of the prerequisites necessary to ensure good health and wellbeing. My research seeks to investigate if the use of volunteering as a tool can help vulnerable people develop the skills they require to enhance their autonomy and self-esteem therefore enabling them to take control of their own lives and the factors which impact upon it.

The PBVTP was allocated ring fenced funding for a given period of time because of its link to the volunteer recruitment programme of the 2012 Olympics. However if health and wellbeing and other benefits can be demonstrated it may be possible to revive the delivery of this programme albeit in a slightly modified format. Results will be important for those who deliver the programme and may encourage other organisations to become involved. My research therefore may be valuable for helping people not in education, employment or training to access volunteer training programmes and as a consequence improve their own health and wellbeing.

Public Health Interest

My professional interest in public health and health promotion spans many decades. Prior to working as a university lecturer I worked as a nurse, initially within the acute surgical setting, however I was very quickly drawn to work in primary care in the field of public health, where I was actively involved in promoting the health of individuals, families and communities in the United Kingdom and within a variety of European countries. Much of my work involved working with clients to improve their social and health outcomes. I was fortunate to work with a wide range of people from different social classes, ethnic groups and cultural backgrounds. My work gave me insight into how different groups responded to the various key health education messages of the time, for example: smoking cessation, regular exercise and healthy eating. I was soon aware some individuals or groups found changing their health behaviour more difficult than others. Some groups placed much value on the health messages of the time while others found them irrelevant

or unimportant. Many of the people I worked with were able to embrace change but others, although they considered making changes in their health behaviour, were frequently unable to initiate, carry out or complete the changes. However it often appeared that the people or groups who seem to have the most to gain in terms of health and wellbeing were frequently the ones least likely to be interested or motivated to change. People offered a number of reasons for why they were unable to change despite a concern for their health and a desire to make changes. They cited issues of motivation, circumstances, knowledge, ability, skills or a lack of will power but many of these individuals shared low self-esteem and a lack of personal power, it is also true to say that their personal economic and social circumstances appeared to constrain their choices.

As a practitioner my role was facilitative, I supported individuals to identify their own concerns and implement their preferred changes. This statement sounds very simple but the practical reality was far from simple. In my experience marginalised and disadvantaged people with no material power frequently suffer a sense of powerlessness and low self-esteem, which is constantly reinforced through the wider structural circumstances in which they live and work. Unfortunately this is further enforced by health service providers where authoritarian approaches to promoting health are evident. Specific individuals or groups are frequently targeted by organisations indicating a ‘top down’ approach to health issues. Understanding the reasons why some people or groups were more ready, willing and able to make behavioural change soon became something that I was keen to learn more about.

Much of the work that I was involved in at the time, was loosely referred to as health promotion but looking back it is clear it adopted a very health education approach. This approach was popular and in frequent use with practitioners despite its very traditional, narrow, bio-medical, reductionist view of health. While it enjoyed some success it failed to gain ground with groups who were hard to reach or have the most to gain. It is now recognised that this approach fails to acknowledge the constraints of the

social and economic influences on people's behaviours and health choices. My own experiences indicated that adopting a more empowering facilitative approach proved more successful. This approach allowed people to make their own decisions and choices, albeit they often did not conform to the 'recommended' new patterns of behaviour, and they required much support and any change was slow and frequently inconsistent. My confidence in developing this new style of health promoting practice gained new impetus following my MSc in Health Promotion in the 1990s when I felt able to incorporate a more social model of health with an empowering philosophy and emphasis on community development into my practice. However, historical and current practice still generally adopts a health education based and target driven approach to preventive work, although the academic discourse centres on the empowerment approach to promoting health. Adopting an enabling approach to preventive work is an exciting way of working for many health care practitioners, for others it demands extensive changes in their own skill base and practice. Educating practitioners and bringing about change in practice takes time and widespread educational support and resources. Current practitioners argue that although they would like to practise in this way they neither have the time or the skills to do so and as a consequence the more traditional health educational approach with all its limitations is still extensively used by many health care practitioners, in both the acute and primary care settings. As a consequence autonomous clients are able to make effective use of the current educational style of delivery. However, powerless clients who do not possess the internal and external resources to bring about change fail to benefit from such a service.

Given the difficulties that practitioners have in engaging in health promotion it could be argued that mechanisms which enhance and develop the key components required to bring about personal change necessitate further investigation. Indeed much work has been undertaken in health promoting schools to enhance the development of a range of social and personal competencies which underpin autonomy (Weare 2000). It was for these reasons that I used this study to explore another mechanism which may

enable the development of the personal characteristics and resources; including self-confidence, self-esteem and self-belief, required for the development of the autonomous individual.

During my community development work I was fortunate to work with many individuals who volunteered to undertake various activities, posts, jobs and activities for the benefit of their communities. A wide range of opportunities were available with both extensive and minor roles. Some individuals came to the task brimming with experience and confidence, others were anxious, keen to help but daunted by the task, others did not want to be involved at all. My experiences of these initiatives were that they gather a momentum and life of their own and all the people who were involved seemed to benefit at some personal level. My own role as a facilitator became more insignificant as time progressed and I was able to reduce my commitment to the activity in question as the volunteers became more confident and capable. It was almost as if taking on these roles allowed the volunteers to develop a sense of self, to see that they had succeeded in a variety of ways, it enhanced their self-esteem and the way they viewed themselves and their capabilities. It also appeared to impact on other aspects of their lives, including: personal and professional relationships, aspirations for the future, job opportunities and feelings of wellbeing. In my experience all of the efforts I had seen invested by health practitioners into the health education approach had not facilitated the type or extent of change these volunteering opportunities engendered in people.

As a consequence I was keen to use these experiences to underpin the research for my Doctorate in Education and I started to look for volunteering opportunities to evaluate from a public health perspective, I was particularly interested in opportunities offered to individuals not in education, employment or training as in my experience these individuals may have confidence and self-esteem issues and lack interpersonal communication skills.

BIOGRAPHY

My study adopts the biographical approach, which utilises an assortment of life documents from a range of sources, including written and or verbal accounts (Erben 1998). Biography is concerned with the personal meaning ascribed to the lived events and how people create themselves and their realities (Savin-Baden and Howell Major 2013). Narratives are closely associated with biographical methods and relate to the accounts or stories that make up life course events (Erben 1998). My work uses the narratives of 6 students, who have completed the PBVTP, to provide the basis for the data collection within this study. The participants in this research construct themselves and their roles as volunteers in light of the dominate discourse of drug and alcohol dependency, with many of the participants having experienced social marginalisation and isolation from their families, communities and society. My work acknowledges that the terms drug addict and alcoholic are socially constructed (Dingelstad *et al* 1996). Participants use their narrative to make sense of their life and Personal Best experiences and construct their own stories in order to communicate their own personal meanings to the researcher.

My research offers a humanistic orientation to analysis of the data in that it places the participants at the centre of the process and acknowledges the intersubjective relationship between the participant and researcher. Thematic analysis provides a systematic way of uncovering meaning in the data. It allows the researcher to become very conversant with the generated material, as it involves repeated handling of the data thereby enabling an extensive in-depth knowledge of the information. Braun and Clarke (2006) suggest that it is an effective method as it allows for researcher intuition and sense and is not bound by ridged restrictive rules. A fuller account of this method and how it is used in the research will follow in the methodology chapter.

RESEARCH STATEMENT

This research aims to understand the influences and benefits of the PBVTP from the participants' perspective through the use of their biographical narratives.

Objectives

a) to explore the self-reported personal and social resources acquired by people who have completed the PBVTP paying particular interest to self-reported assessments of self-esteem

b) to investigate the personal perceived health and wellbeing experiences of the participants.

DISSERTATION STRUCTURE

The remainder of this chapter provides an overview of the design and content of the subsequent chapters within my dissertation.

Chapter 2 Literature Review

Chapter 2 reviews the literature within the fields of health, health promotion and volunteering. It seeks to demonstrate that volunteering and health promotion interventions have similar aspirations, in that they pursue the development of individual, community and societal benefits. The chapter begins with a review of the concepts of health and wellbeing and provides some background on the disagreement amongst various professional bodies and organisations on the meaning of the terms and how this influences their policies and approaches to health work. The work then moves on to consider the impact of the social determinants of health on health outcomes and personal health choices and discusses the importance of addressing these influencing factors. The study continues with a review of the ideology which

underpins the modern health promotion movement, concentrating on the personal resources which underpin empowerment and the development of autonomy.

The second part of the chapter addresses key concepts within volunteering, in particular issues of access to volunteering opportunities and the recognised benefits of volunteering. The work then seeks to review the personal and social value of volunteering for socially excluded groups and how volunteering contributes to health and wellbeing. The chapter concludes with an over view of the study which draws together the aspirations of volunteering and health promotion which both seek to promote the development of the personal resources of autonomy, self-confidence, self-belief and self-esteem.

Chapter 3 Methodology and Method

The focus of Chapter 3 centres on biography as the means of data collection for this research and the implications and dilemmas faced by researchers using biographical narrative approaches. The data analysis and the steps taken to reveal the two main research outcome themes and the associated sub themes are also discussed within this chapter. This research has raised a number of ethical considerations and these will also be addressed.

Chapter 4 Findings and Discussion

This chapter commences with a vignette for each of the six participants. These short biographies of the respondents' lives set the research within a lived, time context. The names of the respondents have been changed to protect their confidentiality and false names are assigned to each person. Subsequently the chapter presents the common themes found from the themative analysis and provides an interpretation of the identified themes with regard to previously discussed literature.

Chapter 5 Conclusion and Reflections

This final chapter summarises the study findings and offers recommendations for both practice and further research. However as a reflective practitioner I found that it was a natural extension for me to reflect on all aspects, areas and stages of this research. Therefore I have included these reflections at each phase of this written document. The final chapter also acknowledges the relevance of my own biography with regard to key issues such as values, motives, employment, age, gender, sexuality and ethnicity and how these factors specifically apply to me and therefore to the production of knowledge within this research.

Chapter 2

LITERATURE REVIEW

INTRODUCTION

This chapter will set the scene for this thesis by reviewing the germane literature in the fields of health, health promotion and volunteering. The study seeks to investigate the personal and social benefits of the PBVTP, which is aimed at 'hard to reach groups'. This chapter therefore seeks to examine the existing researched outcomes of volunteering for health and the promotion of personal and social health resources. In doing so it considers the wider field of volunteering, although it concentrates on the motivations and benefits of volunteering and pays particular attention to how volunteering works and its use and value for socially excluded groups. The chapter commences with a critique of the social gradient of health and then discusses the concept of health and the ideology which underpins the modern health promotion movement. It also explores empowerment and autonomy and the key attributes which underpin these terms, namely self-concept, self-esteem and self-belief. The chapter seeks to demonstrate the importance of autonomy and social participation for healthy lives and how volunteering may contribute to this process.

SOCIAL GRADIENT OF HEALTH

Although there is general acknowledgement that the health of the population is largely improving, numerous publications have identified differences in morbidity and premature mortality amongst social groups. Although the Black Report (Townsend and Davidson 1988) is now very dated it was the first significant publication in the UK to identify that for almost every type of illness people in the higher socio economic positions fare better than those in the

lower social economic groups. This seminal report also demonstrates geographical and gender differences in people's health outcomes. In 1998 the New Labour government commissioned the Acheson Report (1998) to further investigate the health gap. This publication again shows a continued increase in the health gap between the rich and poor which can be explained by socio-economic causes such as education, employment, income and lifestyle. This key report calls upon the government and government agencies to address these issues through various policy strategies. However recent work by Marmot (2010) still indicates that there are continued major differences in health between those with the most advantage in society and those with the least. For example life expectancy for men in Glasgow's most deprived and most affluent areas differs by 12 years in 2005, while for the same period in London the difference in the life expectancy gap for men was 11years (Marmot 2010).

Various reasons for the disparities in health outcomes have been offered, although none have been as convincing as Marmot's (1999) Whitehall I and II studies. This longitudinal research of ill-health and civil servants demonstrates a social gradient in health. The research establishes that those in control of their working lives are less likely to suffer from type II diabetes, coronary heart disease and metabolic syndrome. Civil servants at the bottom of the hierarchy show a four times higher rate of premature mortality than those at the highest point of the hierarchy. While civil servants in the middle have twice as high premature mortality rate than those at the top. Interestingly Marmot then demonstrates that this phenomenon appears in every society, even those societies deemed classless, such as America and Scandinavia. His work maintains that there are two major influences on health. See figure 1. In this diagram health is supported by two main pillars. The first includes material resources essential for good health; access and availability of healthy food, water, sanitation, housing, public health services, crime free neighbourhoods and opportunities to exercise. The second involves control of life experiences and incorporates individual and community empowerment. Individual empowerment involves personal

autonomy. Marmot maintains that people who are disempowered lack autonomy, have little control over their lives, experience a greater possibility of mental health problems and increased risk of heart disease.

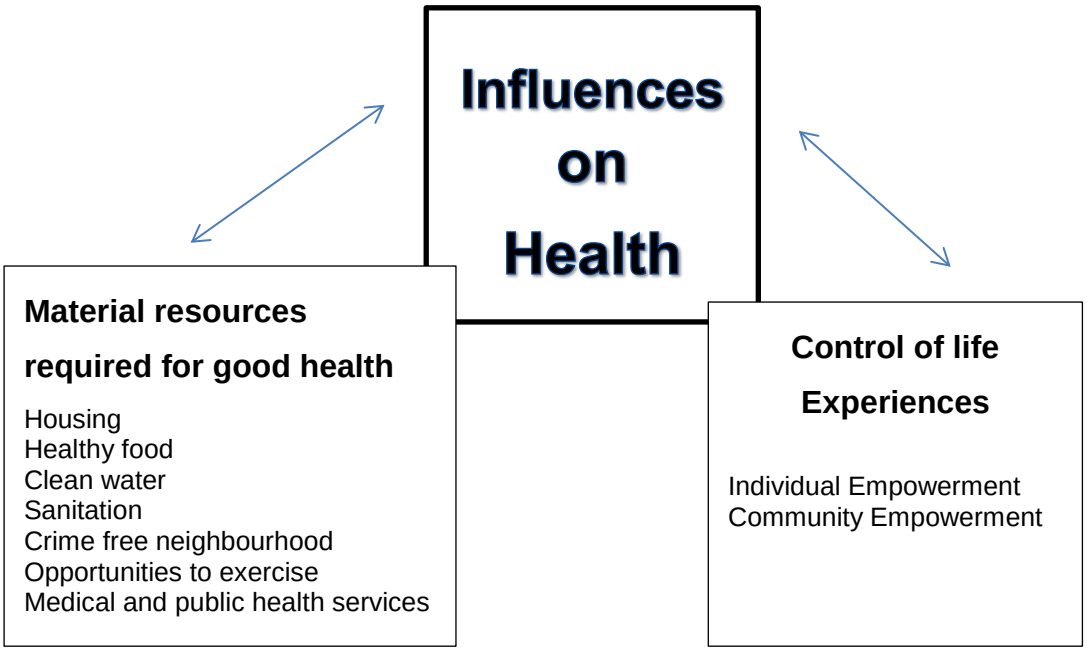

Figure 1: Marmot (2006) Health Influences

He advocates the action of social participation; where individuals take their place and part in society and as a consequence share the benefits of being involved within society. The benefits they gain include; social networks, social support, being valued, improved self-esteem and other social, emotional and psychological resources. The second concept within this pillar is empowerment at a community level, as this is seen as a valuable way of securing resources for health. For example communities uniting to identify and demand services and support for better health outcomes.

Marmot's work contends that these elements are closely influenced by social hierarchy. The lower people are in the hierarchy of society the less control they have and the less they are able to participate in society. Marmot (2006) explains that control is not just about who makes the decisions at work but relates to all aspects of life. He offers an example of the single mother who is

overwhelmed by responsibility, has few resources and is unable to participate in society. Another example is that of low resourced individuals with family responsibilities who suffer employment instability. Marmot (2006) maintains that the social and economic conditions of individuals determine their degree of autonomy and the greater the limitation the worse their health outcomes. He proposes that people with low social positions have decreased opportunity and therefore lack empowerment and security in their lives.

Marmot's premise builds upon Wallerstein's (1992) seminal work on power and powerlessness. His work demonstrates that powerlessness, or a lack of control over one's fortune and future appears as a risk influence for disease. In contrast empowerment, which is more difficult to measure and assess, can be regarded as a strategy for health enrichment. Work by Link and Phelan (2000) also acknowledges the importance of a sense of control in life for health. They suggest that people who have a sense of control are better at coping with stress and have the resources to implement a healthy way of life. They call it 'social power' and suggest that it provides a feeling of safety and wellbeing which promotes health. In contrast low resourced people lack the power to control their lives, have few material resources, are prevented from adopting a healthy way of life, do not manage stress well, suffer more illness and die earlier. However Nathanson and Hopper (2010) offer concerns regarding Marmot's 'taking control of one's life' mantra, as they maintain that on its own it does not provide a guarantee of good health. Indeed rampant individualism can contribute to resentment, self-centredness, jealousy and social disintegration (Weare 2000). Nevertheless work by Doyal and Gough (1991) supports the premise that there are two basic human needs, health and autonomy. Whereas Sennett (2003) links autonomy, self-esteem and the earning of respect and suggests that all people have a basic requirement for self-esteem and autonomy. Marmot (2003) therefore contends that people should seek autonomy as a means of achieving good health; he argues that low levels of autonomy and low self-esteem are likely to be linked to poor health.

The World Health Organisation (WHO) (2006) maintains that social support from family, friends and the community at large is an important influence for health. Stansfeld (1999) suggests that strong social support and links between people contributes to healthier people, he acknowledges that although the mechanism is not fully understood, it involves people feeling loved, appreciated and respected and includes social and emotional resources provided by others. This mechanism is thought to mitigate or help in the management or reduction of stress. Interestingly results from Marmot's Whitehall studies indicate that individuals in the highest employment positions enjoy the widest social networks and highest supporting relationships. However this group may have more friends because of their high social mobility or it may be that the nature of their housing and communities encourages more informal neighbourly relationships (Marmot *et al*. 1997). Social participation and social capital are recognised as bestowing valuable protective and enhancing health properties (Wilkinson 1996) and their influence and benefits will be discussed later in this chapter.

Marmot (2006) demonstrates a strong link between social economic groups and non-communicable disease; he contends that non-communicable disease is caused by smoking, poor diet, lack of physical activity, excess alcohol and other determinants. Low income correlates with less material resources and therefore fewer capabilities. However he maintains that people's use of their limited resources is linked to their personal control and social participation. People with less control are more likely to suffer non-communicable disease caused by long term direct neuroendocrine pathways (chronic stress) which are further influenced by behaviours related to alcohol, nutrition and physical exercise.

Social Conditions and Biological Pathways.

Marmot (2006) maintains that there are strong connections between people's social conditions and their biological pathways. Earlier research suggests that ill health and chronic disease are linked to exposure of a long term

inability to control one's environment, this causes prolonged stress which has a physical impact on the body (Marmot *et al*. 1997, Bosma *et al*. 1998). Further work by Bosma *et al*. (2005) demonstrates that beliefs about personal control over life are allied to a greater risk of heart disease. Other studies have identified that the mechanisms which link psychosocial factors to the metabolic syndrome are the autonomic nervous system and hypothalamic pituitary adrenal axis (Marmot 2006). When people suffer prolonged periods of stress there are changes to the levels and production of cortisol and this causes the development of the metabolic syndrome, which is instrumental in the development of type II diabetes and heart disease, both of which contribute to premature mortality.

Currently much health promotion work adopts a strong traditional health education basis, which seeks to address issues such as smoking cessation, obesity and alcohol reduction. Health service practitioners predominately encourage and persuade people to modify or change their health behaviours, largely ignoring the more powerful impact of the wider social determinants on health. The results of Marmot's studies would seem to suggest that health promotion should adopt a different focus while the work of the World Health Organisation (WHO) 1986 strongly advocates an empowering approach in order to support the development of autonomous individuals. However this method is not universal, mainly because it is necessary to have a clear definition and agreement on the concept of health before health can be promoted. However this elusive term continues to be much debated.

UNDERSTANDING HEALTH

Marmot (2006) contends that health is an important marker of a country's ability for its citizens to lead flourishing lives. To achieve this aim countries employ a number of strategies including health promotion. However in order for health promotion to work towards the improvement of health and wellbeing, it is necessary to agree an understanding for the terms and this is not as simple as it sounds, as there is a lack of agreement of what

constitutes health. Wills (2007) proposes that although health is a major and pivotal concept, it has different meanings for different groups of people. Green and Tones (2010) suggest that the chief difficulty is whether to consider it in a positive way, where it is seen as an asset, or negatively where the focus is on the absence of disease. These ideas can exist either at different ends of a continuum or coexist, both influencing the other. Some, such as Trent (1992) advise that the linear concept of a continuum is too simplistic, while others prefer the idea of dimensions of health which refer to the overlapping dimensions of mental, social, emotional, spiritual and physical health as this abstract notion is more likely to encapsulate the complexity of the concept (Cribb and Dines 1993).

Defining Health

Seedhouse (2002) identifies and summaries the key theories of health and acknowledges that they propose fundamentally different ways of considering health. The theories include looking at health from a medical reductionist perspective, which views health as an absence of disease with high levels of functional ability (Ewles and Simnet 2010). However supporters of a more holistic approach criticise this model for concentrating too much on the physical body ignoring the mental and social aspects of health and dismissing the social causes of much illness. They prefer to extend the definition of health to be multi-dimensional and to include social, emotional, mental, environmental dimensions (Aggleton 1991). Conversely Seedhouse (1997) suggests that holistic definitions equate health with happiness and by doing so demand infinite requirements of the health services and as such are of little practical use to health practitioners. Green and Tones (2010) critique the utopian ideas of health and agree that although they may be inspirational they are in reality unattainable and are therefore of limited value to practitioners. Current obsessions with healthiness adopt a disease avoidance approach which encourages people to avoid negative states of health by behavioural activities which concentrate on exercise, diet and lifestyle activities. However work by Antonovsky (1996) challenges this

fixation with risk factors and healthiness and offers the salutogenic model, which views health as a continuum, focusing on health enhancing conditions leading to wellness rather than disease avoidance. These ideas are also seen in Maslow's (1943) influential concept of reaching one's personal potential through his hierarchy of self-actualisation, where he stresses the importance of positive self-concept and self-esteem in that quest.

Seedhouse (2002),following his review of a range of studies on health, concludes by advocating that as there is no agreement on a single definition, the major theories could be combined to provide a unified view of health as a foundation for human achievement. Health can therefore be perceived as a means to an end rather than a static state of being. He proposes that:

> *"A person's (optimum) health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance to all people. Others are variable dependent upon individual abilities and circumstances."* (Seedhouse 2002, p.94)

Considering health in this way recognises the importance of the identification of internal personal resources but it also limits the current health promotion work of health workers as this broad definition throws up practical priority difficulties and challenges (Naidoo and Wills 2009). However Blaxter (1991) argues that health practitioners must have an understanding of lay perspectives of health, which frequently incorporate aspects of biomedical, coping with life, functional ability and resilience notions and that accepting the client's definition of health is the key to promoting their health. Seedhouse (2002) simplifies the argument by proposing that the major aim for working for health is to create as much autonomy as possible, in other words health is the achievement of autonomy. This important concept will be discussed further at a later stage in this chapter.

Frequently the term wellbeing is currently used in preference to health or linked to health, it is therefore appropriate to now include a discussion of this term.

Wellbeing

Green and Tones (2010) favour the more progressive term of wellbeing to health, because it acknowledges the multi-dimensional view of health. However frequently the terms health and wellbeing are strung together, or wellbeing is seen at the positive end of the spectrum of health or viewed entirely on its own as a component of mental or emotional health (Thorogood and Coombes 2010). United Nations Children's Fund (UNICEF) (2007) defines wellbeing as a single issue and believes that it involves having the rudimentary external items which people require for a safe, healthy, happy life, whereas the Office for Economic Development (OECD) (2006) maintains that wellbeing is gained by having individual wants and preferences satisfied. And that a person's wellbeing develops through self-interpretation of personal interactions with their environment, emotions and other people. Dodge *et al*. (2012) concede that there have been many attempts at defining wellbeing and suggest that most definitions have centred more on the dimensions and descriptions of wellbeing rather than defining the term. They suggest that people are constantly seeking a state of equilibrium and to achieve this they try to balance the challenges of life against their available resources. They recommend that this definition has appeal because it can be applied to all ages, genders, cultures and acknowledges that people are managers of their own lives. While Marks (2012) recognises that wellbeing is not a static entity, but more like a dynamic dance where the movement enhances functionality. The Office of National Statistics (ONS) (2013) recent extensive measurement of national wellbeing demonstrates a strong relationship between levels of overall life contentment and satisfaction with health. These findings are mirrored by the results obtained from an extensive national survey on wellbeing by the New Economics Foundation (Nef) (2012), which indicate that although wellbeing is a broad concept which

encapsulates happiness it is also concerned with how satisfied people are with their lives. They offer a definition which summarises three major aspects; emotions, competence and satisfaction.

> *Wellbeing can be understood as how people feel and how they function, both on a personal and a social level and how they evaluate their lives.* *(Nef 2012, p.8)*

Feelings relate to emotions such as happiness and anxiety, whereas function involves a sense of competence and being connected with people that surround an individual, while evaluation measures the satisfaction people experience in their lives. Nef (2012) maintain that wellbeing is a balance between external and internal drivers. External drivers include a person's income, housing and education and these are balanced against internal drivers or personal resources of resilience, autonomy and self-esteem. In this sense autonomy is seen as a resource and it would therefore appear that the development of autonomy and the other internal drivers are deemed to be essential for the improvement and maintenance of wellbeing. There is acknowledgement from National Health Service North West (NHS NW) (2010) that good levels of wellbeing underpin people's capacity to make healthy lifestyle selections, to manage and cope with illness when they become ill, to recuperate better from illness and to seek out and use services and resources appropriately. Wellbeing is clearly an important asset for individuals and this study seeks to investigate if the PBVTP can equip the participants with the internal personal resources necessary for the development of wellbeing.

Autonomy

Autonomy is seen as a highly valued and fundamental aspect of modern health care and health promotion although Arpaly (2003) identifies eight different uses of the term autonomy and suggests it has several different

domains. Within the field of health Beauchap and Childress (2009) argue that autonomy is a person's ability to make knowledgeable, intended decisions with regards to life goals and preferences, without the direction of external influences. Although this definition is favoured in health work it assumes that individuals are autonomous already and that health workers are respecting their autonomy by facilitating well informed decision making. However in reality there is considerable evidence to suggest that many people especially low resourced individuals lack autonomy and as a consequence they see the health education information they are offered as having little value or bearing on their lives. Consequently they are unable to make use of this information because of the constraining influence of the social and economic context of their lives (Green and Tones 2010).

This discussion has demonstrated that health remains a complex concept and different people are likely to have different perspectives on health. The powerful but narrow medical approach to health dominates the thinking and practice within health care in the west, although some argue for the importance of the social elements in the creation and meaning of health. However this raises significant implications for health promotion, as perceptions of health will influence how and what type of health is promoted.

Promoting Health

There is considerable debate regarding definitions of health promotion. Should it be viewed as an umbrella term, which encapsulates a number of activities and disciplines involved in improving population health or should it be considered as a discipline in its own right. As a standalone discipline it would be expected to have its own underpinning ideology, whereas Seedhouse (1986) suggests that health promotion is a magpie construct which has borrowed and combined so many different ideas from numerous diverse disciplines thereby preventing the development of a clear unifying central ideology. This causes practical difficulties for practitioners when they define what health promotion attempts to achieve and how this can be

facilitated. Despite the clarity of the WHO's Ottawa Charter in 1986 Kelly and Charlton in 1995 also argue that health promotion remains a mass of contradictions, both within its underpinning theoretical base and practice. And this theme continues to be echoed within nursing literature on health promotion practice today.

The Department of Health (DH 2004) includes the term health promotion within its definition of public health, adding health protection, and clinical quality, as well as the reduction of health inequalities. This definition recognises the influences of the social determinants on health outcomes and acknowledges that the field of public health has an important role addressing these powerful factors. Various epidemiological studies on the causes of ill health demonstrate that much premature mortality and ill health can be prevented or alleviated (Hubley and Copeman 2013). Preventing ill health is seen as a much less costly option than providing the relevant health care (Kelly and Charlton 1995). It also ensures that people are in better health and can therefore remain in the workplace and provide for themselves and their families, thereby contributing to the wealth and resources of the nation and reducing the cost and provision of social benefits. Promoting the nation's health therefore seems to be a logical method of addressing these health issues.

Health Education

Green and Tones (2010) maintain that within current public health here is a heavy emphasis on the consequences of individual behaviour and health problems such as; obesity, smoking and sexually transmitted infections rather than identifying the cultural and environmental causes of human behaviour. As a consequence health promotion practice has used epidemiological and economic risk factors as a basis for action. This ideology has translated into the delivery of a strongly behavioural lifestyle approach, which places much emphasis on using health education information to attempt to change what is seen as 'negative' and harmful to health individual

behaviour. This approach has resulted in the creation of a ‘victim blaming attitude’ to clients who fail to change their behaviour, as it does not recognise the social and economic contribution of society and the environment on an individual’s behaviour and health (Black Report Townsend and Davidson 1988, The Health Divide Whitehead 1987, Acheson Report 1998 and the Marmot Review 2010) and therefore does not seek to address or develop autonomy or the other necessary resources required to underpin personal or community behaviour change.

Many individual health education interventions such as smoking cessation initiatives, which subtly suggest that smoking is an irrational costly activity, have been criticised by Oakley (2005) for failing to take into account the structural constraints in people’s lives. Her research indicates that although the women in her study were very aware of current medical knowledge on the dangers of smoking, the information they received was insufficient to change their behaviour, because they used smoking to manage the stress in their difficult lives. The study demonstrates strong links between the women’s behaviour and social class, culture and gender and a lack of personal autonomy. These results resonant with Graham’s (1987) earlier work with women, who smoke on a low income whilst caring for young children. As a consequence Naidoo and Wills (2009) maintain that health promotion interventions aimed at individual change cannot rely solely on education and persuasion alone, they must have an awareness of the wider social framework in which these behaviours operate. However Kelly and Charlton writing in 1995 argue that this moves health promotion into a political dimension highlighting issues that need to be resolved in the longer term but fails to concentrate and address the health concerns of the day. Nevertheless in reality much of current health promotion offered by health care workers adopts this traditional educational approach to health promotion and merely involves offering clients health education and hopes that this knowledge alone will encourage behaviour change. In reality non autonomous clients are constrained by other factors in their lives and are unable to make use of this information and are prevented from changing their

behaviour. However the healthier and wealthier members of society, with access to a wider range of resources, are able to locate and utilise this information to good effect thereby increasing their health stock.

Empowerment

In an attempt to address these issues in 1986 the modern health promotion movement emerged with its influential foundling document, the Ottawa Charter (WHO 1986), which places people and community empowerment at the heart of health promotion. Subsequent WHO conferences and publications have clarified its health promotion stance stating that people should actively participate, individually and collectively in the planning and implementation of their health care (Jakarta Declaration 1997, Mexico Global Conference 2000, Bangkok Charter 2005 and Helsinki 2013). Nutbeam and Lincoln (2006, p.7) suggest that health promotion is the most 'ethical, effective, efficient and sustainable approach to achieving good health'. While Bunton and Macdonald (1992) believe the WHO has successfully and practically united a wide range of matters, disciplines and points of view within the charter. However Laverack (2004) maintains that the discipline still sits in two main groups; one, which adopts the reductionist bio-medical behavioural approach and the other which takes a social approach which embraces the concepts of enablement and wellbeing.

The Ottawa Charter (WHO 1986) advocates health promotion as an enabling, empowering service and maintains that the process of empowerment is fundamental to individuals and groups as it enables the development of the capacity of choice thereby giving people control over their health decisions. Kendall (1998) suggests that empowerment allows clients to gain knowledge, skill sets and attitudes required to cope with the changing world and life circumstances. Empowerment can be seen as both a process and consequence and is defined by Gibson (1991, p.359) as

> *A social process of recognising, promoting and enhancing peoples' abilities to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control of their lives.*

This definition has strong links with the previous discussion of autonomy and the internal and external resources that people require to enhance their autonomy and therefore their health. Seedhouse (2002) suggests that any work for health must involve the identification and elimination of any barriers to health. However this may cause difficulties for health care practitioners who are frequently constrained within the medical model of working, as a consequence he proposes the following definition for promoting health

> *work for health is essentially enabling. It is a question of providing the appropriate foundations to enable the achievement of personal and group potentials. Health in this degree is about removing obstacles and by providing the basic means by which biological and chosen goals can be achieved.* Seedhouse (2002, p.94)

Weare (2000) agrees and counsels, that promoting health must be concerned with the attributes that individuals need to acquire to enable them to take control of the factors which influence their own health and the health of their communities. While Labonte (2004) suggests that individuals need to develop the capacity of choice and Werner (1988:1) adds that by becoming empowered 'disadvantage people are able to work together to increase control over their lives'. This point is taken up by Labonte (2004) and Scriven and Stiddard (2003) who maintain that a crucial aspect of empowerment is that it needs to be functioning at both a community and individual level to be successful. Earlier work by Beattie in 1991 advocates a redistribution of power and active participation of those who are intended to

benefit from the action; suggesting therefore that empowerment is an activity which is done with, not to people.

For Keiffer (1984) empowerment is linked with mutual support, personal efficacy, competence, self-sufficiency, self-esteem and support systems. Tones (2001) acknowledges these empowerment characteristics, recognising that they are important aspects of behaviour and behaviour change. While Scriven (2005) proposes that the aims of empowerment within health promotion are to promote various personal characteristics and skills including psychological perception, cognitive development and life skills. Areas of enhancement within psychological perception include self-esteem, self-efficacy and an internal locus of control; these are discussed further in the next section. For cognitive development; critical consciousness raising, the relevant health education information is required. With regard to life skills it is essential for the individual to develop decision making, assertiveness and interpersonal skills. Nevertheless Weare (2000) cautions that empowerment on its own for individuals can lead to antagonism, egoism, rivalry and social disintegration. While Marmot (2006) maintains that empowerment does not infer that some people should gain more privilege at the expense of the health and wellbeing of others. Weare (2000) uses the term social empowerment and suggests it involves united groups of self-empowered people who work co-operatively to build jointly supportive communities for the benefit of all.

Weare (2000, p.28) acknowledges that the aim of the health promoter is not to direct the person's behaviour but to facilitate and enable people to achieve their own goals and the goals of empowerment including 'self-determination, independence, autonomy and freedom', which are influenced by social and affective education. Green and Tones (2010) suggest that the ultimate purpose of empowerment strategies is to foster the development of what they refer to as 'internality', i.e. the internal personal resources which underpin autonomy and by doing so empowerment will have an indirect impact on health by influencing individual and community action.

A key factor for health promotion is how to promote the development of these personal attributes. At a practitioner level the social approach to health promotion seeks to encourage a positive salutogenic perspective to health and wellbeing. It aims to cultivate and improve an individual's personal sense of self-worth, self- confidence, self-esteem, value and control thereby helping people to develop a range of coping mechanisms in order to make them more robust when dealing with life events (Laverack 2005). Indeed Antonovsky's (1979) salutogenic approach highlights the influences which generate and sustain health and wellbeing rather than concentrating on the adoption of the negative disease approach. He identifies coping mechanisms as a measure for keeping people healthy despite adverse environments, stressful life events or change. He uses the term 'a sense of coherence', which he maintains involves the importance of a sense of control over life events and is composed of three important elements:

- Comprehensibility - people see the world as ordered and structured rather than chaotic and unpredictable.
- Manageability - people have the resources which help them manage their lives.
- Meaningfulness - people are committed to goals and life makes sense emotionally.

Tones (1998) advises that these and other life-skills are required by individuals for the development of autonomy and they may be acquired and advanced in many ways, including within the family, at school, or through community development, or self-empowerment and via various educational, health or counselling consultations. Life skills which contribute to autonomy, involve building an accurate self-concept, the acquisition of self-esteem and the development of self-efficacy (Weare 2000).

Empowerment Concerns

The theory of empowerment within health promotion emphasises that life skills and resources can be developed at both a community and personal

level. However the reality appears to be somewhat different. Although the WHO (2005) supports the twin core values of individual and community empowerment and accentuates the importance of disease prevention and the promotion of wellbeing rather than concentrating all actions on costly medical treatment and care. Laverack (2005) maintains that many Government health promotion strategies and interventions involve power over communities by professionals, rather than the sharing of power. Earlier work by Kelly and Charlton (1995) voices disquiet about the idea of ownership and control within community empowerment. The concept suggests that individuals and communities identify their own health concerns and ways of addressing them and by doing so they develop the necessary skills for personal autonomy. However Kelly and Charlton (1995) maintain that in reality it is the experts who support and direct the community and that they are still in control maintaining their strong connections with the paternalistic medical model of health and as a consequence individuals have little opportunity for development. Funding for many community interventions is also frequently in the hands of external organisations, with experts controlling the choice and achievement of targets and use of funds. These factors may prevent individuals within the community taking control of the initiatives or identifying other change scenarios.

Laverack (2005) suggests that another major issue concerning communities is that they are not generally homogenous; they are frequently composed of diverse individuals and groups who may have competing interests and a wish to gain control of decisions and resources. This competition may contribute towards poor community cohesion or indeed a breakdown of community relations and as a consequence some members of the community may gain empowerment at the expense of others. This may cause further fragmentation and isolation for some with increased stress for other vulnerable members of the community.

Laverack (2005) also poses the idea that not all people want to be empowered and the right to empowerment must rest with the individual or community. However he suggests that if people have lived in conditions

where power has always been maintained over them they may not have the motivation or feel they have no right to be empowered. He proposes that this may happen for people who have lived for long periods of time within the constraints of poverty, as a lack of personal control has contributed towards low self-efficacy and low self-esteem. Tones (2001) recognises these personal attributes as the underpinning concepts of empowerment, he maintains that they are pivotal in providing the foundations and opportunities for future behaviour change. Key figures in this field Seedhouse (2002) and Marmot (2006) also advocate that the major aim for working for health is to create as much autonomy as possible and they urge practitioners to work towards enhancing client autonomy and campaign for national health strategies which improve individual and community autonomy

The Self

Charmaz (1999, p.209) defines the self from a sociological perspective. She maintains that the self-possesses his or her own identifiable talents, characteristics, principles, attitudes, emotions and morals and over a period of time humans collect an extensive range of information about themselves. Alternatively Brown (1998) writes that humans are aware, thinking, reflexive beings, who have the ability to see and think about themselves and their actions. He refers to the duality of the self, which involves the I-self and the Me-self. The I-self is the actively doing self which thinks, interprets and organises, whereas the Me-self concentrates on who the person is and what people think of them. This second aspect, the Me-self, is linked to self-concept. Burns (1992) suggests that the views and assessments people have of them governs their understanding and belief in themselves and influences their actions and their future behaviours. These significant influences are linked to an inner core which guides and controls behaviour and aspirations throughout life. The feelings and internal mechanism are known as self-esteem and self-concept. This study seeks to explore the influence of the PBVTP on the participants' self-concept and self-esteem.

Self-concept

Identities are continually moulded as individuals evaluate other people's opinions of them (Brown 1998). The participants within this study may have redefined their personal and social identities post their drug and alcohol addiction and mental health breakdowns. Addicts and people who suffer with mental health difficulties often experience stigma and suffer further because of the negative attitudes directed at them. This may have the effect of negatively re-enforcing a poor personal self-identity and therefore a poor sense of psychological wellbeing. These self-identities are internalised and contribute towards the development of self-concept. Baumeister (1999) defines self-concept as a person's belief about himself/herself and their attributes. The concept is concerned with the process of the construction and defining the self in relation to the outside world and is a lifelong process. This multidimensional and hierarchical structure becomes differentiated with age and experience. Lewis (1990) believes that development of a concept of self has two aspects; the existential self and the categorical self. This involves the self and another for contrast. Although Rogers (1961) suggests that self-concept has three elements, which include self-image, a view the person has of themselves, self-esteem how much value they place on themselves and the ideal self, who they would really like to be. The self-concept is a precursor to self-esteem and is created by interactions with others chiefly those of importance to the individual, namely family, peers and teachers. It is comprised of thousands of diverse opinions about the individual and can be both encouraging and negative and is coloured by emotions (Weare 2000). In order to function capably in society people require a truthful valuation of themselves in relation to others. However individuals with poor self-concept are less likely to adopt health enhancing behaviours and as a consequence may be further stigmatised by their families, the health services and the general public (Laverack 2005).

Self-esteem

A major determinant of behaviour change is self-esteem (Weare 2000). Harter (1990) defines self-esteem as the overall value that one places on oneself as a person and suggests that it provides a global evaluation of the self-concept. Additionally Weare (2000) proposes that childhood experiences are important for the development of positive self-esteem in adulthood, as children need to enjoy a sense of being loved unconditionally by adults who behave consistently, while Argyle (2008) acknowledges the importance of parents and carers in the development of self-esteem. In contrast Judge and Bono (2001) suggest that self-esteem is a trait, which although is fairly stable over time, can be prone to situational influences, while Greenhalgh (1994) proposes that self-esteem is the single most significant gauge of positive self-concept and is substantially influenced by the way people are treated, how much people feel valued by others, achieve success, realise their own aspirations and the amount of control they think they have in their lives.

Argyle (2008) believes that self-esteem is influenced by four key elements. Firstly he stresses the importance of the reactions of other people. When people are complimented, respected or flattered they are more likely to develop a positive self-image but when they are criticised, ignored or mistreated they are more likely to develop a negative self-image. Secondly he states that people constantly compare themselves with other members of their peer group. If the comparison shows that other people are richer and happier, others may develop a negative self-image whereas if peers are less successful then the self-image may be positive. Thirdly he believes that there are some social roles such as being a doctor, pilot, or successful business persons which enhance self-esteem whereas being a mental health patient or drug addict carries stigma. Finally he suggests that people internalise these roles and the membership of groups combine with their societal image. Within their narratives the study participants discuss their experiences of societal marginalisation and exclusion and its impact on their self-concept and self-esteem.

Kendall (1998) acknowledges that self-esteem is deemed to be an important aspect of mental health in western countries and Green and Tones (2010) maintain that it contributes to the health choices people make and that the differences between an individual's ideal self and their actual perceived self is likely to contribute to low self-esteem. While Glick and Zigler (1992) report that low self-esteem leads to maladjustment, whereas high self-esteem contributes to wellbeing. The rationale is that people, who value themselves, are more likely to look after themselves and therefore adopt behaviour which prevents disease. Control and lack of control are key facets of self-esteem, a lack of control combines three key effects: it disturbs the ability to learn, reduces motivation and creates emotional disturbance (Green and Tones 2010). Bandura (1986) submits the premise that individuals with low self-esteem are more open to persuasion and as a consequence are more likely to be swayed by others into adopting harmful health behaviours, such as smoking, drinking and drugs, whereas people with high self-esteem are able to exercise control by resisting. MacDonald (1994) proposes that positive self-esteem is critical for mental, emotional and social health. High self-esteem has been shown to be an important factor in an individual's ability to cope with disease and post-operative survival in bone marrow transplants (Broers *et al*. 1998) and has been found to be the central and most influential predictor of happiness (Zimmerman 2000). This suggests that self-esteem is an important trait for health and the adoption of health enhancing behaviours. However it is also important that individuals believe that they are capable of bringing about the necessary and desired change in their behaviour. Self-esteem has also

Work by Mann *et al*. (2004) indicates that the outcomes of low self-esteem are multiple and can cause reduced self-appreciation which contributes to risky behaviours, social problems, psychiatric vulnerability and self-defeating attitudes. They identify three clusters of outcomes for low self-esteem. The first involves the significant role poor self-esteem plays in the development of a variety of mental health conditions, such as depressive illnesses, anorexia nervosa and personality disorders. The second cluster relates to poor social

outcomes and external problem behaviours, such as violence, aggression, dropping out of school and youth delinquency. While the third cluster indicates the link between low self-esteem and risky behaviour such as alcohol, drug abuse and tobacco use.

In contrast Mann *et al*. (2004) maintain that positive self-esteem appears to provide a protective factor for various stressors. And this combined with supportive social networks renders people less susceptible to stressors (Rutter 1992).

A number of initiatives have attempted to improve self-esteem, self-concept and self-efficacy and these will be discussed later in this chapter.

Self-Efficacy

Bandura (1977, 1995) maintains that self-efficacy is the belief that an individual has about their ability and competency to carry out a type of behaviour. It is thought to be a key factor in behaviour change as it determines how much effort an individual will invest in carrying out a particular behaviour. Research by Ewart (1992) demonstrates that interventions aimed to improve self-efficacy enable patients to cope better following a heart attack. While work by Homan and Lorig (1992) indicates that self-efficacy is an essential factor in the development of self-management skills for chronic disease.

Promoting self-efficacy is therefore seen as an important task within behaviour change. Bandura (1977, 1995) proposes that there are four main elements which influence self-efficacy beliefs; these are direct experience, vicarious experiences, verbal persuasion and physiological state. The PBVTP incorporates these main elements within the programme. It provides both theoretical learning in the classroom and practical learning with other agencies and volunteers within volunteer practice placements. Within the different settings students are given opportunities to observe skilled behaviour, to participate and to practice evidence based behaviour and

receive helpful feedback on their performance and behaviour from peers and the course tutor. Davies and Macdowall (2006) advise that learning which involves observation and participation provides the skills for behaviour change and enables the development of self-confidence and self-efficacy. Whereas Green and Tones (2010) are more specific, they acknowledge that self-efficacy beliefs are strongly reliant on past experiences of either successful or failed mastery of a specific behaviour. Therefore learning which seeks to promote self-efficacy must facilitate the development and acquisition of the skills and competencies required to carry out a specific type of behaviour and identify and remove any environmental obstacles. Most importantly it must positively influence the efficacy belief directly. Consequently learning which attempts to encourage efficacy needs to incorporate opportunities for role play, observation of credible and admirable role modelling, anticipatory techniques, verbal persuasion and most importantly learning opportunities which provide prospects for success. The following section offers a brief overview of studies which have attempted to nurture self-concept, self-esteem and self-efficacy.

Fostering Positive Self-concept, Self-esteem and Self-efficacy

Weare (2000) suggests that teaching and learning have a central role in the promotion of mental, social and emotional health and therefore it seems that school may be a natural setting for this venture. Hallam (2009, p.313) reports mixed early results on the Social and Emotional Aspects of Learning programme (SEAL) which was ‘designed to develop children’s social and emotional skills within primary school’. The teaching staff were generally positive about the programme which showed an improvement in levels of respect amongst students and reduced bullying, while head teachers reported that use of the programme appeared to engender positive attitudes towards the school. Reports show clear gender differences with boys having lower self-esteem scores than girls although there was improvement over time.

A meta-analytical review of 116 ‘self-esteem’ interventions studies for children and young people by Haney and Durlak (1998) shows that most studies illustrate noteworthy increases in positive self-esteem and self-concept amongst children and young people, with marked improvements in behaviour, personality and academic ability. There are a number of studies for adults but many of them are linked to specific diseases or health conditions and as a consequence it is not possible to draw generic inferences on self-concept, self-esteem and self-efficacy as the behaviour changes only relate to the targeted condition, or compliance with specific treatment. This research offers the opportunity to explore changes in self-esteem and self-concept as a result of the PBVTP and is not therefore limited to a specific health condition so any changes have the potential to have a positive impact on all aspects of an individual’s social, emotional and mental health. As discussed a positive self-concept, good self-esteem and a belief in one’s abilities are important health protective factors. These internal resources are further enhanced when linked to social participation and social capital.

SOCIAL CAPITAL

Wahl *et al*. (2010) describe social capital as a multidimensional concept which incorporates a wide range of varied ideas, they distinguish between individual and collective social capital. Collective social capital is recognised as a communal quality which is developed and owned by the community and from which the community benefits. While Lin (2001) views individual social capital as a pool of resources upon which an individual can draw and argues that the quality and extent of these resources will differ between people, dependent on their socio economic status, occupation, environment and community. These resources can be beneficial in providing a wide range of valuable information to individuals including the provision of social and emotional support, however it is necessary to invest time and energy to create and sustain the networks (Hawe and Shiell 2000).

However Bourdieu's (1983) definition of social capital regards it as largely an attribute of the ruling classes and the way in which they maintain and concentrate their positions of power and privilege and many community practitioners would agree with this explanation of social capital as they have first-hand evidence of the reality of structural power within communities (Hawe and Shiell 2000). Coleman (1988) offers a contrasting perspective he proposes that people living in marginalised communities or members of the working class can benefit from the possession of social capital. He highlights the importance of the family, friendship networks and religious organisations in the creation of social capital and suggests that social capital facilitates the growth and development of reciprocity, trust and individual action. While Putnam's (2000, p.19) seminal Bowling Alone publication explores the concept in more depth and maintains that social capital denotes the connections between people and the 'norms of reciprocity and social engagement that foster community and social participation'. Putnam suggests that the social connectedness of social capital delivers networks which provide information which is valuable in helping people achieve their aims and by doing so improves their lives. He advises that social capital also encourages people to work co-operatively to resolve shared difficulties. Secondly he proposes that when people are both trusting and trustworthy they are more likely to engage in multiple social interactions with others, which as a consequence are more enjoyable and enable better community relations and activities. Thirdly he maintains that social capital widens people's awareness and their opportunities to test their ideas and views, thereby reducing impulsive actions and poorly thought through opinions.

Putnam also identifies two types of social capital; bridging and bonding. Bridging social capital is where bonds and connections are formed across assorted groups, while bonding social capital is formed in groups of comparable people. Both types may co-exist although one may be stronger, dependent on the nature of the community. Putnam expresses concern when there is lack of bridging social capital; he maintains that although bonding social capital is valuable in that it unites a group, it can also exclude

outsiders. Therefore the effect of only having bonding social capital within a group or community may perpetuate inequality and exclusion.

Portes (1998) defines social capital as membership of social networks and structures which provide benefits. He divides the concept into two elements; relational and material. The relational element is integral to the social organisation of which the individual is a member, while material involves the resources bestowed on the individual for his membership. Woodcock (1998) adds to this by suggesting that there are two aspects of the relational element; embeddedness and autonomy. He argues that at a micro-level embeddedness involves the degree to which an individual is assimilated into their networks, while autonomy signifies the freedom an individual has to establish networks outside their immediate group. In contrast macro-level embeddedness is the interaction between the actions of the state and the interests of the people, while macro-level autonomy is the capability of organisations to act independently of vested interests. Social capital therefore appears to operate at a number of levels and in different ways but attempts at successfully measuring it have enjoyed mixed results. Hawe and Shiell (2000) comment that the power of social capital is within the social networks therefore analysis of the networks may provide beneficial information for the health.

Since the 1990s social capital is recognised as having an influence on health largely as a consequence of its direct and beneficial impact on individual attributes and activities (Wahl *et al*. 2010). Hawe and Shiell (2000) note that a major supporter of social capital is the World Bank, which is now the largest global health agency with regards to the assets it makes available to initiatives within developing countries. A key aim of the World Bank is to increase the wealth of developing nations as it recognises that education, health and social capital are pre-requisites for economic growth. The bank has set up a Social Capital Thematic Group, which brings together a network of advocates, researchers and practitioners in order to develop theory, practice and policy within the field of social capital.

Lomas (1998) argues that the way society is organised, the interactions amongst its citizens, the degree of trust people have in each other and the level of caring in one's community are probably the most important determinants of an individual's health. While work by Wilkinson (1996) demonstrates the existence of a strong correlation between income inequality and ill health. They argue that living in a highly imbalanced society leads to feelings of humiliation, lack of respect and embarrassment for those who have a lower position in the social hierarchy. This inequality corrodes social capital and amplifies differences in social status, which increases psychosocial stress causing ill health and destructive health behaviours, such as drug and alcohol addiction. However much public health effort, attention and funds are currently directed at screening initiatives, lifestyle changes, behaviour modification and immunisation, although developing social capital and participation within communities is known to enhance personal and community health stock and to provide a range of valuable personal resources for individuals and is also seen as a way of addressing health inequalities (Marmot 2006).

Social networks are a key aspect of social capital, they are thought to provide social support and assist relational bonding which influences physiological stress responses, self-esteem and health behaviours thereby enhancing health, while social exclusion and isolation are linked to higher levels of ill-health (Green and Tones 2010). Social capital is thought to act as a buffer in times of stress by providing emotional and social support, thereby thwarting health damaging behaviour and contributing towards improved quality of life. See Figure 2 for Wahl's *et al*. (2010) adapted diagram which makes the relationship links between demographic and social characteristics, social capital and the personal resources of coping and self-esteem and health and quality of life outcomes (Wahl *et al*. 2010, p.809).

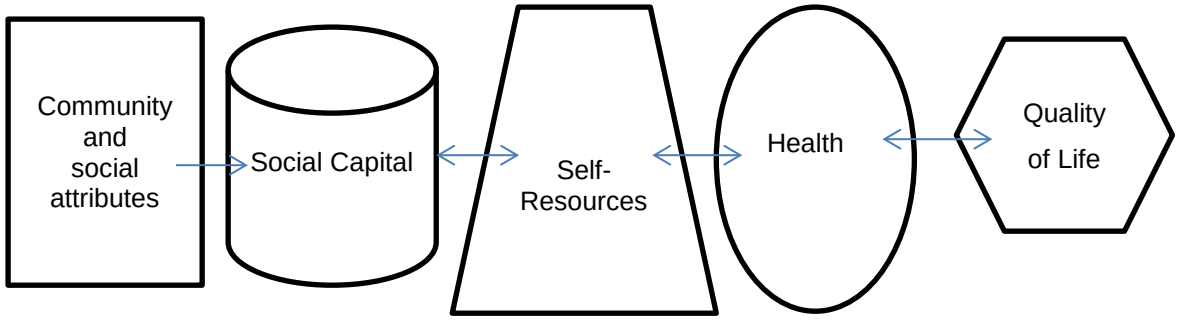

Figure 2: Relationship between community characteristics and quality of life outcomes (adapted from Wahl *et al*. 2010, p.809)

Work by Mittelmark (1999, p.447) identifies a number of channels which demonstrate how the personal resources within social networks enhance an individual's health stock;

- Provision of information to assist people in stressful situations and avoiding risk.
- Positive role models
- Increased feelings of self-esteem, self-identity and control over the environment
- Social regulation, social control and normative influences
- Sources of real support
- Sources of emotional support
- Perceptions that support is available
- Buffering actions of others during times of stress

However Hawe and Shiell (2000) argue that power and powerlessness are key factors within health inequalities and relational networks are insufficient to combat material deprivation and learned helplessness. They maintain that practitioners working in this field need to become political campaigners in order to challenge these socio-economic environments. A key factor according to Wallerstein (1992), in his seminal work on power, involves

empowerment and the active participation of people and communities towards increased community control and social justice. Marmot (2006) echoes these ideas arguing that individuals and communities need to be actively involved in all decisions that affect their lives. In order for this to happen he maintains that there must be major investment in the social fabric of society so that individuals have a feeling of belonging to communities and that communities have the opportunity to develop the characteristics of social capital. He reasons that social and political conditions need to change so that all people, regardless of their socio-economic background should have the freedom to lead the lives they value as this has a major influence on their health and wellbeing.

In summary this section has offered a review of the literature with regard to the importance of the development of autonomy and empowerment for health and wellbeing outcomes. The work now proceeds to a review of the literature on volunteering. As previously stated the aim of this study is to explore the biographies of people who have completed the PBVTP in order to investigate its influence on their self-esteem and autonomy. It is therefore relevant to now consider the literature with regard to the personal and societal benefits of volunteering.

VOLUNTEERING

Developing the skills for volunteering and engaging in volunteering placement opportunities provides the basis of the PBVTP. Therefore this section of the chapter will review the literature in this field with regard to the skills and resources which can be gained during volunteering activities. This work seeks to explore the benefits of the PBVTP for the participants, paying particular regard to health outcomes, the development of autonomy and self-resources.

Defining Volunteering

The starting point for a review of volunteering must be to identify a shared meaning for the term volunteer. On the surface it appears a comparatively simple concept to define but in reality the term is multifaceted and work by Cnaan *et al*. (1996) suggests that there are extensive differences between and within countries on how volunteering is both seen and defined. Dingle (2001) argues that volunteering should meet three criteria. Firstly the volunteer should not be coerced into taking on the role, although there may be peer and family pressure to volunteer this is not considered as compulsory. Secondly the volunteer should also receive no financial reward, but reasonable expenses are acceptable and finally the volunteer's actions should benefit a third party, which can include the volunteers' friends and family. However Musick and Wilson (2008) remark that if volunteering is seen as doing unpaid work then there is some similarity between membership of a voluntary group and volunteering, although merely attending meetings or enjoying the benefits of a voluntary organisation does not constitute volunteering. Work by Davis Smith (2000) proposes that a fourth criterion should also be considered in that volunteering may incorporate an organisational setting. There appears to be a range of ideas within this element from; all volunteering should be carried out through formal non-profit making organisations, to the opposite, that an organisation need

not be involved and the nature of the volunteering could be both formal and or informal.

Davis Smith (2000) also offers a view on the different volunteer activities and suggests there are broadly four areas to consider. The first involves mutual aid or self-help, which in many countries forms the basis of social and economic provision for the bulk of the population and can range from small informal groups to large scale organisations providing support, in various guises and help to many, these services may be connected with a social, sporting or therapeutic need. The second is philanthropy or service to others and is more a feature of developed countries although it is seen elsewhere. In this case the people who benefit from the volunteering are not members of the groups themselves. This type of volunteering generally takes place in charitable organisations at a national or local level. Volunteers in large organisations may move from one region or country to another in times of need. Davis Smith (2000) terms the third type of volunteering participation. In this case individuals are representatives on user-groups or government consultation bodies for various initiatives or development projects. This type of activity is a key feature of a civic society. The fourth type of volunteering is advocacy or campaigning, which may involve petitioning for change or raising public awareness on a range of concerns, including environmental, human rights or health.

From this discussion it can be seen that volunteering activity can take many diverse forms, from the provision of one to one informal support; to sport coaching for local children, to encompassing people who are working together to carry out a task to benefit the community or identified individuals. Therefore this work accepts a broad understanding of volunteering, which includes both formal and informal volunteering and sets the volunteering activity within a wide range of settings.

Extent of Volunteering

The Voluntary Action History Society was established in 1991 in London in response to the limited historical knowledge of charity, philanthropy and voluntary organisations. Although volunteering action and charitable organisations have a long history, as can be seen from the writing of Tocqueville (1835) in the United States, the topic has never been considered in its own right but only as a minor aspect of social policy. However participation trends appear to have been broadly constant with some small changes over time. According to the National Citizenship Survey of 2003 (Home Office 2004) in the United Kingdom 28% of the population were involved in formal voluntary activities and this figure increased to 44% in 2005 with a further Citizenship Survey. A more recent assessment is seen in the Helping Out Survey (Low *et al*. 2007) which indicates that 59% of the survey sample had undertaken formal volunteering within the last year, with 39% of that group volunteering on a regular basis, that is at least once a month. However this survey, which deals only with volunteering, is keen to point out that factors pertinent to this survey may have encouraged higher reports of volunteering in this sample group, although considerable government volunteering initiatives over the last 10 years may also have influenced the increase in volunteering figures. More recent UK data from the Citizenship Survey 2010-11 (Department for Communities and Local Government 2011) indicates that informal volunteering rates were higher than formal volunteering, with 39% of people saying they volunteered formally at least once in the last year as opposed to 55% of people who said they volunteered more than once a year informally. However this data indicates a noteworthy decline since 2007 despite continued efforts of government.

Volunteering also has an economic impact. In 2003 42% of people in England volunteered 104 hours in 12 months through a group, club or organisation, if this was seen in cash terms this contribution would be worth around £22.5 billion (Home Office 2004).

Who Volunteers?

Work by Pearce (1993) indicates that married individuals with families and more resources are more likely to volunteer and have a dedication to the activity. This is confirmed by Plagnol and Huppert (2010) whose work shows that wealthier, more educated people in good health who are married, religious and either live in larger families or have higher incomes are more likely to volunteer than others. Although Musick and Wilson (2008) propose that education is the strongest predictor of volunteering, in that it develops thinking skills, raises awareness of local, national and global issues, nurtures empathy for others and develops confidence. People with higher education also have more social contacts and educational qualifications which again increase their opportunity to both volunteer and be invited to volunteer.

A wide diversity of organisations including businesses recognise the benefits of volunteering for their organisations, the development of their staff as volunteers and the sharing of expertise amongst the wider community and as a consequence have set up and encourage volunteering schemes.

Volunteering and Socially Excluded Groups

The UK government has developed a number of schemes to promote volunteering to groups who would not normally get involved in such activities. There has been much interest in using volunteering as a way out of social exclusion. The term social exclusion is used for people or communities who experience a range of difficulties; including unemployment, low resources, limited skills, deprived housing, high crime rates and family breakdown (Office of the Deputy Prime Minister 2004). There is increasing research interest into this underrepresented group but there is still much to be investigated. Tomlison's (2010) work explores the use of volunteering as a way into paid employment for refugee women and maintains that in order for these women to be successful they have to disengage from their own communities and embrace multiple identities. While Yap *et al*.'s (2010)

research concentrates on how volunteering is seen as a way of modelling and demonstrating the attributes of a good citizen for another group of refugees who seek to gain social approval by their volunteer activities. Whereas Bowgett's (2006) study evaluates a project which was set up to promote volunteering to homeless people and her findings indicate that homeless people are interested in volunteering and are able to gain many benefits particularly in terms of raising self-confidence, increased self-worth and improving employability opportunities, nevertheless they also face a number of barriers including fear of losing welfare benefits when they volunteer and negative attitudes from other volunteers from other social groups. Sixsmith and Boneham's (2003) research involves volunteers from socially excluded groups in a deprived community and although it indicates that volunteering engenders joy, pride, self-respect and confidence in members of these social groups there were also negative components which include a feeling of powerlessness to bring about change, hurtful criticism from the local community, squabbling, infighting amongst volunteers and burn out. Despite some of the negative results it is evident that the positive effects of volunteering may have a key role in helping socially excluded people and groups back into social participation.

As a consequence over the past 10 years the government has launched many schemes to promote volunteering to groups of people who are not normally involved in volunteering; including; young people not in training, employment or education, long term unemployed, ex-offenders, and those with mental health illness. More recently the Government has commissioned SkillsActive to secure providers to deliver the Personal Best Volunteer training throughout England; there are currently around 50 providers. Personal Best is a volunteer training programme specially designed for unemployed and socially excluded people; it uses the London 2012 Olympic and Paralympic Games as a motivating force to help enhance trainees' aspirations and help them into further learning and the workplace and is the focus of my research.

Benefits of Volunteering

The benefits of volunteering can be viewed from various perspectives, from benefits to the individual volunteer, to the organisation providing the service, to the individuals or community receiving and giving the service and to the wider society. The evidence suggests that the remuneration to volunteers for volunteering appears to be multiple and lasting (Astin *et al*. 1999). A review by Wilson and Musick (2000) reveals that volunteering can, amongst other things, increase physical and psychological wellbeing, generate social networks, develop occupation and career opportunities and reduce isolation. Haski-leventhal (2009) maintains that elderly volunteers are more likely to report increased life satisfaction, raised self-esteem, a feeling of usefulness and improved access to support systems, while Wilson (2000) proposes that volunteering keeps people healthy, although research suggests that people in good health are more likely to become volunteers.

Studies identify that volunteering is a mutually beneficial process for both the volunteer and the community. Indeed Gaskin (2004) offers that volunteering is seen as an exchange relationship where volunteers receive a range of benefits as a result of their contributions. Volunteering promotes self-esteem and self-confidence and increases overall life satisfaction (Harlow and Cantor 1996) and according to Wheeler *et al*. (1998) volunteers have a better quality of life than non-volunteers. Although work by Meier and Stutzer (2006) suggests that helping people increases happiness levels and Baines and Hardil (2008) maintain that it offers a source of personal identity. While Thoits and Hewitt (2001) write that healthy, content people are more likely to offer more of their time to volunteering activities, which as a consequence promotes further personal wellbeing. Research by Milligan and Conradson (2006) confirms that volunteering makes a contribution to the wellbeing of individuals and communities. Although House *et al*.'s (1988) study proposes that volunteering provides a way for people to become involved in their communities and it is this integration in community which enhances and promotes their own good mental health. Indeed Putnam (2000) maintains

that social connectedness is vital to lives and he goes on to say that the more connected people are to their communities the less likely they are to experience colds, heart attacks, strokes, cancer and depression. He also suggests that civic connections are predictors of life happiness and that there are lower premature death rates for people involved with volunteer work than their counterparts who do not engage in these activities.

Work by Tocquevile as early as 1835 paired the development of active citizenship with volunteering. More contemporary work by Putnam (2000) also acknowledges the social and community activity provided by volunteering which builds social capital and supports communities by providing valued services which would be expensive or unaffordable or unavailable if not offered by volunteers. Indeed Wilson (2000) also suggests that volunteers fight antisocial behaviour by helping people become more connected to their communities. While Kearney's (2003) article on volunteering and community cohesion accepts that volunteering has a role to play in building a cohesive and connected society, it also recognises that more work is required to find out what types and form of volunteering are most likely to encourage and facilitate the development of social capital and develop volunteer skills to enable volunteers to contribute to community regeneration. Work by Milligan and Fyfe (2005) shows that processes within voluntary organisations can facilitate or constrain the development of active citizenships, the latter is particularly relevant when organisations are growing and delivering professional and complex welfare services. It would appear from research by Lee and Brudney (2009) that volunteering decreases as the opportunity costs of volunteering increase, but conversely if people see themselves as more integrated into their communities they are more likely to engage in volunteering. This is confirmed by Bowgett (2003) who proposes the use of volunteering for the creation of stronger cohesive communities and that volunteering may be a way out of social exclusion as it helps individuals to develop personal and work skills thereby improving employability chances.

Indeed the UK coalition government's Big Society advocates a move away from a top down controlling role and seeks instead to release constraints on community engagement and give local people more power to take decisions to develop their own locality (Directgovt 2010). The power of volunteering and its benefits for a society's civic health are central to the ideology of the Big Society, as volunteering is currently seen as an indicator of a healthy positive society (Bowgett 2006). Work by Putnam (2000) in the US suggests that the majority of a country's resources should be focused on the groups or individuals who have the most to gain, the benefits of strengthening social capital are he suggests; reduced crime, enhanced educational achievement and the nurturing of better health. He maintains that this work must take place across communities, developing and supporting commitment and capacities and involving already present community groups. Putnam (1993) demonstrates the importance of social capital for health, wealth and wellbeing of the population and communities. His ideas are captured by the UK coalition government's Big Society concept which seeks to encourage individuals to shoulder more social responsibility and develop safer and friendly neighbourhoods as the quality of networks and level of infra-structure within communities strongly influences health and wellbeing outcomes for individuals (Gillies 1998). Work by Lomas (1998) focuses on the importance of social systems and health and states that public health practitioners are spending too much money and focusing too much attention on changing individual behaviours and lifestyles rather than increasing social cohesion and interaction in communities which is probably the most important determinant of people's health. These sentiments are supported by Graf (1991) who suggests that volunteering schemes may be a better method for promoting peoples health and wellbeing. While Konwerski and Nashman (2008) call for opportunities to enable the sharing of positive, psychological, emotional and mental health benefits of volunteering amongst more groups in society.

Other benefits of volunteering include the development of skills, contacts and credentials, which all contribute to employability (Doyle and Smith 1999).

Again these factors seem to be reciprocal since Wilson and Musick (1999) suggest that high resource people, who can be measured by their education, income, occupation and race, compete better in both the labour market and the volunteer market because they are better endowed with knowledge, skills and organisational abilities. Interestingly it appears that volunteering further helps to equip these already accomplished people with the skills for work and further volunteering. Resources such as information, trust, social networks and connections are equally valuable in volunteering as in the workplace (Wilson and Musick 1999) and this may be why more socially integrated people are more likely to volunteer, although many people are introduced to volunteering by their family and friends and for many volunteering is a social activity.

Reasons and Motivation for Volunteering

The Helping Out Survey (Low *et al*. 2007) also indicates that the most frequent response to why individuals volunteer was to help people, it reveals that 53% of older people volunteer to help people. The second most frequent answer is because of an association to a cause or group and availability of time. It seems that people are also more likely to volunteer with a certain organisation if they or their families have been helped by the organisation or cause. Merely giving something back to the community people live in, was the least common answer. The survey reveals that people found out about volunteering opportunities by talking to other people, i.e. by word of mouth and also by using the services of the organisations and then in turn helping that organisation. Interestingly Putnam (2000) states that volunteering fosters more volunteering, possibly because these people have extended their social networks even further and are therefore more likely to be asked to help by other people and organisations. Indeed Paik and Navarre- Jackson (2011) maintain that being asked to volunteer is a very important predictor for volunteering, while Putnam (2000) reports that people who have been helped by volunteering are more likely to volunteer themselves. Although Holland (1985) writes that people will search out volunteer environments that allow

them to utilise their skills and abilities and to express their values and attitudes, this suggests that there appears to be an element of selection within the decision of who to volunteer for and with.

Many businesses encourage volunteering amongst their staff as a method of staff development and to provide services to individuals and communities. For example the company Ernst & Young has a highly skilled workforce and the company is constantly seeking out opportunities to inspire their staff to use their skills in diverse ways. A major initiative involves volunteer mentoring, which helps staff development and enables the sharing of professional experience with start-up entrepreneurs. Accessing Ernst & Young's highly skilled workforce has been both helpful to entrepreneurs and motivating for Ernst & Young staff members (NCVO 2011).

Work by Batson *et al*. (2002) takes a very different view point and indicates that people volunteer within their communities for one of four motives

Egoism – to improve own welfare
Altruism – improve welfare of others
Collectivism – improve group welfare
Principalism – defend a moral principle

In contrast research findings by Fortier and Auger (2007) on youth volunteering in Canada within sport and leisure show the following varied motivations for volunteering:

- to meet people and develop friendships
- to give support
- to help with developing personal skills and improving knowledge base
- to have fun
- to express oneself and be heard
- recognition
- support
- the methods and success of the recruiting strategy

These researchers also noted that it was important that volunteering opportunities were created and arranged with the young people in mind. They encourage organisations to provide young people with volunteering opportunities which allow them to follow their interests, gain experience, develop their abilities, accomplish their aims and achieve a feeling of responsibility. However organisations also need to ensure that young volunteers continue to volunteer. And again the key factors here include the requirement that the youth enjoy themselves, acquire knowledge and skills and continue to gain success and autonomy from their involvement in the volunteering activities. For many young people volunteering was seen as a leisure activity, although 50% of Canadian youth volunteers admitted to undertaking volunteer work as a way of developing their professional skills.

Motivation appears to differ with age with young people keen to acquire work place skills whereas older people want to contribute to social causes. Research by Clary *et al*. (1992) identifies 6 major psychological reasons for volunteering:

- Values – altruistic beliefs in order to help others
- Understanding - to learn and experience new things and develop life skills
- Career - to gain work place skills and experience
- Social - to conform to peers expectations
- Self-esteem - to enhance personal self esteem
- Protective – as an escape mechanism to hide negative feelings about oneself

Following further research and consideration Clary and Snyder (1999) amended the model to include a further 4 motivational elements:

- Reciprocity – the exchange principle. I or my family may need this service in the future

- Reactivity – volunteering helps the individual address or eliminate past or present problems
- Social interaction – to develop networks and interact with others
- Recognition – to be acknowledged for their contribution

Low *et al*. (2007) also suggest that other life factors can also influence motivation for volunteering, including for example, life events, socio-economic status and personal circumstances. Barriers to volunteering can also prevent people who would like to volunteer from taking action.

Many HE and FE establishments and work organisations are also involved in encouraging their students / staff to engage in volunteering. They recognise the benefits to themselves, their students and the wider community. Their motivations differ slightly to those of the individual. For example Volunteering England (Not Dated) maintains volunteering amongst students improves educational organisations' retention rates as students access new experiences which enrich their interest and enthusiasm for the course and college. It also promotes the profile of the college / university within the community and shows how the establishment is giving something back to the larger community.

However as previously noted much of the research on volunteering has centred on those who are volunteers and the benefits they can accrue. Barriers to volunteering have been identified but little work has been undertaken with the group who are at risk of social exclusion and yet who may also benefit from the identified advantages of volunteering. Sixsmith and Boneham's (2003) project concentrated on working class people in deprived communities and reported that there was a complex set of motivations underpinning volunteering but also a desire to improve their own lives and their children and other people's lives. A common picture throughout the western world indicates that people from low income households, people in poor health or with disability, the unemployed or the socially excluded are less likely to volunteer and essentially to some degree are socially excluded

from volunteering (Haski-Leventhal 2009). Poorly educated people are more likely to say that they do not volunteer because they do not know how to go about volunteering (Musick and Wilson 2008). The Helping out Survey (Low *et al*. 2007) indicates that black and minority ethnic groups who have no qualifications or have a disability have lower rates of volunteering. However work by Haski-Leventhal (2009a) maintains that volunteering reduces social exclusion and isolation and can empower people to give and not just be on the receiving side of volunteering activity. People from socially excluded groups can therefore benefit from provided volunteering services but also by being volunteers themselves. Indeed Haski-Leventhal (2009a) goes further by proposing that prohibiting socially excluded people from volunteering further excludes them from the identified benefits.

How Does Volunteering Work?

Although there is some literature on the benefits of volunteering there is little work on how it brings about some of the reported changes. However it is possible to look at the reasons of why people volunteer and attempt to track how this instigates change. For example people often work towards a desired aim or personal value. As a consequence they volunteer with organisations which are important to their way of thinking or ideals. The result of this is that the individual takes pleasure from seeing the actualisation of their values and this enhances their sense of identity and self-concept (Teske 1997). This feeling is further enhanced when their volunteering behaviour is acknowledged or admired by others, boosting both their self-esteem and self-belief.

Synder *et al*. (2000) recognise volunteering as a mechanism for ego-enhancement and personal growth as it allows the exploration of personal abilities and helps towards the promotion of self-identity. While Musick and Wilson (2008) acknowledge that volunteering also provides direct learning experiences. It allows people to practice their communication and organisational skills; it often challenges their problem solving skills and

improves their knowledge base for certain topics. Volunteering takes many forms and different volunteering experiences offer different challenges and therefore different rewards. For some, a key reason for volunteering is to gain career related benefits. This may be from exploring different career options to enhancing job prospects. For many the major reason for volunteering is the social aspect and the resulting rewards are the development of friendships and the company of people they enjoy being with. From this activity people gain further social approval for their volunteering behaviour which further enhances their self-esteem.

The 120 hour PBVPT offers a variety of different learning activities, which seek to support the development of self-identity and promote the development of self-esteem as well as providing the volunteers with a range of transferable skills and knowledge for both the role of the volunteer but also for the wider world of work.

For many of the participants the learning opportunities within the PBVPT have the potential to offer major learning prospects, including transformational learning and the development of a platform for change. Mezirow *et al*. (1990) suggests that although all learning results in change not all change is the result of transformational learning. O'Sullivan (1999) suggests that transformative learning involves undergoing extensive, profound changes in the understanding of concepts, emotions and actions, which totally alters the world view of the individual. However changing these previously held world views may take time as often these views have evolved as coping mechanisms and over a long period of time. Additionally Boyd and Myers (1988) suggest that transformational learning involves an individual resolving a personal predicament which then results in an essential change in the individual's personality. Work by Clark and Wilson (1991) suggests that there are three dimensions at the heart of transformation learning and they involve changes in understanding the self, reviewing the belief system and changing lifestyle.

Mezirow (1997) maintains that transformative learning comes about through a rational and analytical process where the individual critically reflects on personally held beliefs, values and assumptions and consciously decides to impose new thinking plans in order to bring about different ways of viewing and living in the world. Although the process may be rational at one level it can have emotional and spiritual elements. However not all agree that it is a rational process some suggest that it also has instinctive, inventive and subjective elements (Grabove 1991). This research seeks to explore the outcomes of the PBVTP for the participants but it also acknowledges that some level of transformational learning is required within the learners for the development of the internal resources necessary to underpin autonomy.

SUMMARY

This chapter has discussed the literature with regard to the definitions of health and determined that although health is multi-faceted and many definitions abound this work accepts that health concerns the ability of an individual to exercise choice over the life they value. The chapter then reviewed the literature surrounding the social determinants of health and concluded that people with the least resources suffer more ill health and die earlier on average than high resourced people. Thus indicating a strong social gradient to health and that the social and economic differences in health status are caused by social and economic inequalities in society. The launch of the Ottawa Charter (WHO 1986) for health promotion advocates an enabling process which aims to facilitate the acquisition and development of personal and social skills and the understanding necessary to ensure good health and wellbeing. It encourages practitioners involved in promoting health to have the skills and knowledge to enable and empower people to take control of their own health and the factors which influence it. However this work acknowledges that although it is the aim of the health service to promote autonomy there are many obstacles to the development of such an empowering style of practice. Therefore other ways of enhancing autonomy

and helping people to develop the skills necessary to become autonomous are required. One method which may be able to provide the skills and internal resources for the development of autonomy is volunteering.

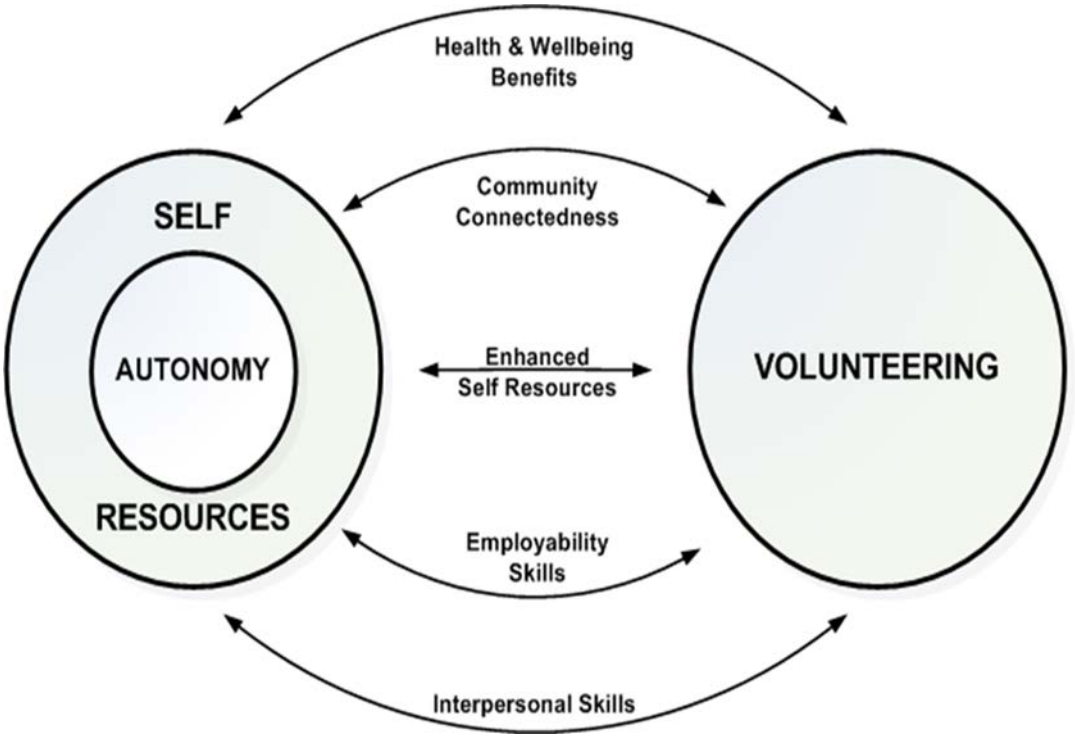

Figure 3: Benefits of volunteering to the individual

Figure 3 provides an illustration of the range of resources which can be gained and further developed by the individual through volunteering. The expanded benefits contribute towards enhanced self-resources and the development of personal autonomy, both of which are essential to future health and wellbeing gains. Although the diagram is static it seeks to demonstrate the reciprocal nature of volunteering for individual asset development. The individual gains a range of skills from the process and act of volunteering, these include improved interpersonal skills, the development of employability skills, improved self-concept, self-confidence and self - esteem, a wider range of social networks, which contribute to community connectedness and an array of health and wellbeing benefits.

Volunteering provides a wide range of benefits to both the volunteer and the wider community, however people who are most likely to volunteer are generally well educated and from the higher socio-economic groups. There is limited information on the benefits of volunteering for socially excluded people, although evidence suggests that volunteering increases social capital and social integration amongst this group, however this is not guaranteed as many disadvantaged groups may experience further disadvantage within volunteering recruitment. This thesis explores the idea that helping vulnerable people not in education, training or employment into volunteering schemes will have the potential to help them develop the resources necessary to enhance their personal health and wellbeing.

Chapter 3

METHODOLOGY AND METHOD

INTRODUCTION

This chapter offers a discussion on the rationale for the choice of biography within this research and identifies a number of important ethical issues which the researcher must address when employing this method.

PHILOSOPHICAL STANCE

It is usual for researchers to offer their philosophical and personal stance when discussing the choice of research methodology, although some authors advise against too rigid a position in this area particularly within the field of social sciences, as they maintain that the social world lacks order and cannot be easily separated into different areas and viewpoints (Thorne *et al*. 1999). Donmoyer (2001) agrees and suggests that maintaining strict boundaries between differing philosophies and paradigms can embellish differences unnecessarily. To provide clarity Savin-Baden and Howell Major (2013) propose the idea of a continuum with some researchers at one end adopting a totally purist position and others at the opposite end of the spectrum preferring to use a blended philosophy. In contrast Silverman (2011) advocates that researchers should avoid having a fixed version of themselves but move between many identities. As a consequence this topic area attracts much debate and disagreement, with some authors (Green 2007) asserting that only one philosophical position is suitable for social research and that this should drive the research topic and methodological decisions, while others maintain that the research topic, its aim and objectives guide the methodological choices.

I have spent much time working within the field of health promotion which, for much of its history has been closely associated with the positivist paradigm, which is reflected within the epidemiological approach to disease prevention. This is acknowledged by Tones (1994) who suggests that the stimulus of other disciplines, which use traditional scientific research methodology, has influenced the development of health promotion ideology. However modern health promotion seeks to understand the lived experiences of others, the impact of social context and the importance of the meanings people make of their environment. A prerequisite for health promotion interventions is the need to incorporate a humanising holistic approach which takes into account the dynamic life processes and experiences. As a health care professional it has always been important and frequently necessary for me to understand the cultural context of people's lives, to appreciate how people make decisions and decode the experiences and events within their lives in order for me to provide a service which promotes and supports health behaviours. For these reasons I was drawn towards an interpretative stance, which seeks to understand people's experiences and the sense they make of world in which they live (Holloway and Wheeler 2010).

Interpretative Position

Interpretivism is generally characterised by the way in which human beings generate their own individual and personal meanings as they interact within the world and the aim of the researcher is to make sense of people's actions, behaviours, beliefs by retrieving the meanings people attribute to them (Minichiello *et al*. 1990). Walsham (1993) writes that all human action is a social construction, including the actions of researchers. To find meaning within a particular action requires the researcher to interpret and achieve understanding or '*verstehen'* (Schwandt 2000:193). Schwandt (2000) quotes the seminal work of Dilthey who argues that to understand human action one must develop an empathic identification with the individual by 'getting inside their head' in order to understand the action from the inside. Although there is much debate on the likelihood of this activity the analogy it provides is

helpful. The assumption is that the researcher must understand the participants' thinking in order to interpret their actions (Minichiello *et al*. 1990). Therefore interpretivism is both subjective and personal; it seeks to expose many realities, often in an uncontrollable environment using a researcher who is not 'value-neutral' and who therefore will always be implicated in the research findings. As a consequence researchers working in this field must address some key issues including; validity, also known as trustworthiness, truth, generalisability sometimes known as particularizability, access and consent, reflexivity, voice and transparency (Butler-Kisber 2010).These aspects ensure rigour within research and will be discussed within this chapter.

This research adopts a biographical approach as its methodology and accepts Sparkes *et al*.'s (2005, p.138) view that human activity is 'best understood from the accounts and perspectives of the people involved'. The focus of this research is to capture accurately, understand and interpret the subjective meanings the participants employ regarding their PBVTP experiences.

BIOGRAPHICAL RESEARCH

When working with clients in my professional life I have always sought to gain an understanding of a person's present embedded behaviours and lived experiences in the context of their life story. Indeed all health professionals are constantly seeking to create a background picture of people's lives in order to understand their present reality so that future support can be planned with the client. Recognising the importance of the wide myriad of previous life experiences for current behaviour drew me to the use of the biography within this study. The major surge in both interest and use of biographical and autobiographical narrative approaches and life histories in research has been welcomed by many including David (2008) a director within the Social Research Council's Teaching and Learning programme. She maintains that these methods have the potential to offer considerable

insight into the complexities of learning throughout life, in marked contrast to the dominant quantitative methods which are limited to researching characteristics which can be measured and counted.

Erben (1998) proposes that biographical research has both a specific and general purpose; the general purpose is to gain insight into the nature and meaning of a life or lives and the specific is to analyse a life or lives for a precise reason. Whereas Roberts (2002) advises that the aim of biography is to understand and discover what is important to people from their own perspective and outlook. He proposes that this method also has the advantage of aiding understanding of those life experiences against the backdrop of the contemporary context and social setting, thereby assisting the understanding of people's interpretation of their own experiences amidst social change. He goes on to suggest that biographical research centres on 'individuals as creators of meaning' and views the researcher as attempting to understand stories coherently and present accuracy. Erben (1998, p.163) adds that the biographical method regards the individual as a 'complex social identity' within a social structure and in order to develop an accurate understanding of the individual, their values, attitudes, beliefs, behaviour and experiences, biography may make use of both positivistic and interpretive analysis. While Roberts (2002) admits that biographical research is a constantly changing arena where researchers seek to comprehend what people see as important and how best to interpret their accounts of fluctuating experiences and perspectives within their unusual or routine lives.

The types of material which are deemed to be relevant in the biographical research field range from various life documents including diaries, letters, journals, photographs, conversations, field notes and oral histories (Denzin 1989). Erben (1998) proposes that narratives are closely linked to biography, as these are the accounts and stories that constitute life-course experiences. While Ricoeur (1980) stresses the importance of narrative analysis for biographical research, suggesting that time which is common to all experiences is the defining structure of human existence, but only narratives can make these experiences and events comprehensible. However,

Holloway and Freshwater (2007) suggest that the use of narratives within biography is both scientific, although their orientation is towards the social or human sciences, and artistic, as researchers engage with the narratives in a multi-layered way including both emotional and empathic levels.

This work adopts the life story approach which is defined by Atkinson (1998, p.8):

> *The story a person chooses to tell about the life he or she has lived, told as completely and honestly as possible, what is remembered of it, and what the teller wants others to know of it,……..a life story is a fairly complete narrating of one's entire experience of life as a whole, highlighting the most important aspects.*

The narratives used in this research concerns what Denzin (1989) terms self-stories where the teller is central to the narrative. The narrative has a beginning, middle and end and although it is based on life experiences it is made up as it is communicated.

Denzin (1989, p.13) goes on to propose that biography uses stories amongst other life documents, to describe 'turning-point moments' in people lives, with these accounts facilitating access to the inner life of the person. However Derrida (1972) maintains that windows into the inner life are always filtered in some way, either by the narrator, the listener, language, setting, time or context, which as a consequence influences the account. Denzin (1989,p.14) offers the idea that stories are narratives with a plan, a theme; they examine a life or a part of a life, relate personal experiences and exist independently to the narrator. He advises that narrative relies on the participants' written or verbal words and importantly the meaning ascribed to those words by the participants, and it is this which enables access to the inner life of the person. The work of Hollway and Jefferson (2000) acknowledges that the outer world of the respondent cannot be really known without knowledge of the way in which their inner world allows them to see and experience the

outer world; this is where the researcher is required to make that world known to others. Therefore biographical narrative allows access to the participants' world, by providing an understanding of that world through the participants' use of language when recounting life experiences, which encapsulate personal attitudes, beliefs and norms of thinking and behaviour (Holloway and Freshwater 2007).

Epiphanies

In the course of biographical narratives people may attribute meaning to major events in their lives, such as bereavement, child birth, divorce or serious illness. Denzin (1989, p.70) maintains that these turning point moments or epiphanies 'leave marks on people's lives' and the events or experiences are both significant and interactional. Erben (1998) in contrast uses the term specific events and maintains that these events do not need to be interactional or momentous but the effects of the experience will be immediate and far reaching.

Denzin (1989, p.71) identifies four forms of epiphanies.

1 The major event which affects every aspect of a person's life.

2 The cumulative or representative event which involves responses to long term experiences.

3 The illuminative or minor epiphany which is a symbolic representation of a major moment in a long term relationship or an individual's life.

4 The re-lived epiphany where meaning is provided in the reliving of the event.

Biographical research provides insight into people's lives by understanding and analysing these epiphanies. Given the backgrounds of the participants many of them recounted experiences of epiphanies or specific events

although they differed in how they voiced and shared this sensitive information.

This research adopts an interpretivst paradigm recognising that knowledge is the meaning respondents give to the experiences and events in their lives and that reality and knowledge are constructed and exist in people's minds and develop through constantly changing experiences. Gabriel (2012) proposes that human beings continuously seek meaning and meaning is linked and shaped by culture, social reality, customs, chronological time, principles, values, world views or typecasts. Schwandt (1998) adds that this contributes to an individual's view of reality and determines their thinking and actions. Biographical research provides a way of exposing and exploring the knowledge which underpins human thinking and their social reality, thereby allowing human experiences to be studied in context. Kuhert and Russel (1990) are in agreement stating that biographical data can illuminate the processes involved in life events. As a consequence biographical research has the capacity to improve understanding and motives for behaviour, enhance practice and improve people's environments and situations. Volunteering provides numerous benefits for highly resourced individuals; this work using the biographical approach seeks to investigate if improved health and self-esteem resources are available for people not in education, training or employment through completion of the PBVTP. If these benefits are forthcoming for this group, training for volunteering and volunteering as a tool has the power to improve their situations and health outcomes.

The Privileged Researcher

Plummer (2001) recognises that there are many dilemmas within the research process. While Sparkes (1995) identifies that power, privilege and exploitation (intentional or otherwise) are amongst some of the research concerns. Stories are collected in various formats such as; interview data, case histories, event reports or personal stories and the researcher is involved in collecting, compiling and interpreting the data. The very nature of

this type of work raises considerable ethical and moral issues, including the notion that researchers have a right to take on this privileged role of writing for other individuals or groups. Two areas of concern, according to Alcoff (1991) relate to the privileged position occupied by the researcher and the impact this 'privilege' has on the group whose story is being told.

Researchers engage in research for a number of different reasons including; personal interest, to enhance understanding and increase the knowledge base regarding a certain topic or group in society, to further their scholarship, or in an attempt to improve a service or enhance care, for advocacy reasons, some may also seek to gain a reputation, or for financial gain or as in my case for part of a doctorate in education. In 2002 Cummins identified concerns regarding the implications of the new research focus adopted by many British universities in order to meet the Research Assessment Exercise (RAE), now replaced by the Research Excellence Framework (REF) (REF 2014). The system assesses the quality of research in UK higher education institutions (HEIs) and as a direct result is increasing the number of staff within HE who are now more research-active in order to fulfil their job requirements. Clearly this increasing band of people will be seeking out many different areas and topics for research. Notwithstanding this Plummer (2001) asks what right have researchers to march into people's lives, seize their stories and then withdraw with the firm intention of telling that story to others. Addison (1997) suggests that researchers preside in powerful, privileged positions. Their invested power enables them to choose the topic area for their research and this choice is invariably based on their own expertise or interest or the lack of work in that particular field. However having selected the topic for study the researcher will be both guided and constrained by the specific study but the ultimate research choice is largely that of the researcher. Kruks (2005) suggests that not only do they have this invested power but publication and publicity of their research may further enhance their social and academic position. Even, for example, researchers who might in the course of their research seek to increase social justice, reduce oppression and discrimination will often be applauded for their

research effects and in so doing may receive enhanced status and other benefits from the stories they tell, whilst these benefits may not be forth coming for the spoken about group.

As a consequence of recognising these issues the challenge for me is to offer an accurate and truthful representation of participants' stories within this research. However this process is not without its difficulties as Conrad's (2003) study demonstrates by identifying her attempts to represent and interpret the lived experiences of her research participants. These people were from a rural mainly Aboriginal community and they maintained that their problems were determined by their rural environment. Conrad (2006) expressed concerns regarding her ability to speak accurately and legitimately for this group when there were such differences of power, race, language and culture between her own position and that of the group members. This idea is taken up by Alcoff (1991, p.2) who maintains that speakers who tell others' stories have their own 'social location or social identity', and this position will influence 'the meaning and truth of what one says'. Bailey (1998) goes further acknowledging that there is a relationship between a subject's location and their understanding of the world and maintains there are also dominant identities who hold more power and privilege and as a consequence are more likely to be listened to and have their findings valued.

This issue is compounded by the propensity to bias within all researchers, Denzin and Lincoln (1998, p.23) suggest it is part of their 'personal biography', they maintain that researchers see the world and speak from a class, cultural, race, colour and gender viewpoint and this may unwittingly or otherwise influence all aspects of their research. In fact Alcoff (1991) suggests that certain privileged positions can actually be 'discursively dangerous' when privileged people speak for disadvantaged people. She cites the example of Cameron a white Canadian female author who wrote about the lives of native female Canadians but was asked to stop this practice by the women themselves, who defended their position by stating that her work was having a negative influence on the work of the native writers. They maintained that the 'public' were more likely to recognise and

listen to Cameron's discussion on native Canadians, than listen to the actual voices of the native Canadians themselves.

Kruks (2005) adds to this discussion with comments on the work on Privilege by Simone de Beauvoir (1955 cited by Kruks 2005) who acknowledges that privileged position brings with it many difficulties. She maintains that privilege is in short supply and as a result the benefits enjoyed by one group are denied another. Kruks (2005, p.3) identifies different types of privilege including; 'masculinity, whiteness, heterosexuality, nationality, able bodiedness, high social status and epistemic position' and how this privilege has a harmful effect in that it actively excludes other groups and yet for many privilege is invisible and therefore the impact of such privilege may not be seen or recognised by the privileged person. This clearly has an influence on how people of privilege can represent others, particularly when they do not share group membership. A possible logical conclusion and way of addressing this issue is for the researcher to be a member of the spoken about group.

Outsider Research

The importance of group membership for the research is acknowledged by Frank (1995) in his work the Wounded Storyteller where he actually excludes medical staff from the work on illness even though they have extensive knowledge of the illness process. He argues that ill people offer a different narrative on illness than medical professionals who merely look in on the lives of the unwell. He suggests that because of the position the medical staff occupy they in effect relegate ill people to the status of patients and their stories merely become small pieces of a larger medical account, whereas he is determined to offer the narratives of people actually experiencing illness. In addition Richards (2008, p.1719) maintains that researchers have difficulties writing about human experience they have not experienced and this becomes more problematic when writing about people with disability. She writes that when researchers engage in this sort of work the effect is to

generalise and dehumanise the individual's experience and generally fail to embody the disabled person's standpoint. She also suggests that research offered by 'outsiders' is different from 'insider' research. This stance suggests that researchers can only engage in research of groups of which they are members and also assumes that others are able to speak for themselves. Certainly Foucault acknowledges the difficulties of speaking for others, but adopts a different approach (Foucault's Groups d'Information sur les Prisons GIP cited by Atkinson 1997). His group maintained that they could not write in the name of the imprisoned but they could provide the opportunity for the prisoners to tell their own stories themselves. In other words the GIP acted as story tellers and not interpreters or analysts of the stories. Nevertheless Alcoff (1991) suggests that although when some speak for others it may sometimes undermine the spoken for group, but this is not always the case. In some situations particular positions have more credibility than others, for example when a person speaks for others and not about others. This can be used to bring about positive change for a group, or clarity of understanding of a community's plight for the wider population.

As a consequence of this widespread debate within the research community many researchers have opted to deal with the issue of group membership and research in different ways, some have taken the decision to research their own cultural, gender or sexual group others have moved away from this genre suggesting that these groups engage in their own research (Pillow 2003). However Markham (2004) cautions against this approach suggesting that the quality of the research is not improved by simply having indigenous groups doing the writing and maintains that it is the detailed analysis which includes the perspectives and location of both the group members and the researcher which enhances the value of the work. Others have acknowledged that although they cannot abandon most types of privilege, for example gender, heterosexuality, whiteness or nationality, researchers must acknowledge them and be alert to ways of overcoming and resolving some of these issues.

Within this research I acknowledge my outsider position and my professional interest in the research topic. Volunteering provides a wide range of benefits to people who are already highly resourced. Currently there is little research into the area of volunteering amongst people who are not in education, training or employment. Frequently this group of people live on the margins of society, experience social isolation and poor health outcomes while their problems remain hidden from the wider general public. This research seeks to give voice to this group by assisting in the identification and understanding of volunteering as an instrument for improved health outcomes.

Layers of Truth

Erben (1998) in his writing acknowledges the intricateness of human lives and suggests that it is the role of the researcher to capture the life with all its complexities. Undoubtedly this activity will add depth and interest to the research but it may also expose areas where there is a vagueness or lack of 'solid' available evidence, which could contribute to questions regarding the veracity of the work. However there are also other research difficulties which can arise at all stages of the interpretation process. For example slight changes may occur when transcribing the spoken word and nonverbal communication into text and again when editing the text the words may be grouped together in certain ways or linked to other statements. Extra complexities are added if the text is translated into another language, perhaps the language which is more convenient for the researcher or the intended audience (Haigh-Brown 2003). A major benefit of transcribing the data soon after the interview was that much of it was still fresh in my memory and that coupled with the field notes helped to resolve any difficulties with language or terminology. This process ensured that the transcription of the interview tapes genuinely captures the participant's narrative and voice. Although Andrews (2008, p.86) acknowledges that field notes are merely 'interpreted observations' and are linked to the researcher's time and experience which is not static. Different experiences bring new understanding and therefore new interpretations.

Holloway and Freshwater (2007) recognise that validity occurs at two levels in narrative research: the respondent's narrative and the narrative of the researcher who re-presents their story, by transforming it academically and interpreting it. As a consequence Stromquist (2000) suggests that there is more than one way of seeing the truth while Ricoeur (1980) proposes that stories are offered as perceptions of the truth and narratives are transformative, which allows opportunities for reflection on the various events. This therefore allows connections to be forged between the personal event situated in history and the event as seen through the individual's social and cultural lens. Ultimately this aids insight into the way an individual or a group perceives and experiences the world and the influence this has on their behaviour. Ricoeur (1980, p.169) writes that individual actions and societal influence are irrefutably joined within human narratives with chronological time as the 'universal architecture of human existence'.

Both Frank (2000) and Ezzy (2000) maintain that other factors are evident in the story telling process. Frank (2000, p.230) proposes the notion of 'story telling relation', which involves the generation of data between the teller, the listener and the circumstances of the tale, whereas Ezzy (2000) reveals that people may both leave out or embellish aspects of their stories. Clearly both of these issues will impact on the told story, its interpretation and the consequent representation within the research. In contrast Ricoeur (1980) maintains that people use their life events to create plots for themselves as a way of managing the process of living. As a consequence the researcher is required to perform an action of mediation between the told story and the constructed research. As a consequence Plummer (2001) warns researchers against standardising data as these actions will influence people's stories, distorting and corrupting them. He advocates the importance of establishing quality research relationships in order to develop deeper insight and broader meaning. As a result the term trustworthiness is the preferred term in this field. It involves promoting research which is rigorous, clear, transparent and demonstrates the researcher's reflexivity and reflection (Butler- Kisber 2010).

However in reality the ‘absolute’ truth of narratives cannot be established (Bruner 1986), although Holloway and Freshwater (2007) maintain that there is an obligation to accept and believe respondents stories. Indeed there are strong democratic reasons for using the respondent’s voice, as they maintain it is not possible for researchers to know any better or more about the lived experiences related by people as these accounts relate to their lives and their experiences. However they also acknowledge that researchers may hope that respondents’ stories are true although they know that sometimes narratives are influenced by poor memory, errors, muddled thinking and occasionally untruths. Stromquist (2000) maintains that no methodical approach can ensure total truth, however she affirms that qualitative methods are generally more responsive to participants’ views and the situation of the respondents, but indeed the researcher has ultimate power over the situation in that he / she is able to control the selection of data for consideration and to decide upon what is relevant, what is included and what is not revealed.

Lather’s (2000 cited by Butterwick 2003) work considers the influence of the social and cultural identity of different researchers and suggests that opposing hierarchies of privilege and oppression can influence truth and its interpretation. Haigh-Brown (2003) adds that it is not always possible to offer the reader one singular truth as the research may present the narratives of a person whose experiences are distinctive but whose life experiences also go further than the person and extend to the community of which the person is a member and sometimes beyond that community, and therefore multiple truths of the same story may be created. However Savin- Baden (2013) maintains that individuals articulate stories centred on what they believe or wish to represent about themselves, regardless of the ‘truth’. What they offer informs the researcher about the values and perspectives the respondent holds. As a consequence Holloway and Freshwater (2007) state that researchers are still able to develop knowledge from the narratives, as it can provide a unique picture of how that individual views and understands the world.

In summary qualitative research offers multiple constructed realities (Savin-Baden and Howell Major 2013). There is no absolute truth, people have different opinions of reality and they create their own truths. The role of the researcher is to describe how they have come to understand the reality of the participants. This conclusion is relevant to this research, which accepts the participants' biographical narratives as their construction of reality, but also acknowledges that their stories may continue to change over time given the participants' situation and their assimilation of new experiences and knowledge.

The Self in Biography

A major element of biographical narratives involves the multifaceted concept of self. Elliott (2005) acknowledges the complexity of narrative suggesting that it exposes the multiple influences on the self which cause it to constantly construct, deconstruct and reconstruct which consequently impacts on the subjective narrative. As a consequence there has been and continues to be considerable discussion around the concept of self, as Freshwater (2002) concedes that the idea of the self has been described in various ways including; psychologically, sociologically, biologically, spiritually, and in modernist and post-modernist terms. In more recent times the debate has centred on self as characterised by the 'ego' theories and self as characterised by the 'bundle' theories. Supporters of the ego theories maintain that the self is persistent and consistent and fixed, whilst bundle theorists maintain that the unified self is a collection of ever changing experiences, 'where the self is viewed as a story we tell ourselves and others' (Holloway and Freshwater 2007, p.40).

MacIntyre, (1985, p.220, 1985, p.216) a moral philosopher, recommends that the self can only really be viewed in unity within 'a narrative which links birth and death', he suggests that short term goals and behavioural activities can only be understood in terms of long term patterns of being. He acknowledges the complexity of self-hood suggesting that the self is both unique and

connected to others and argues that narratives enable the self to create a sense of the ‘temporal and causal’. While Gergen and Gergen (1988) propose that the self is socially constructed by experiences and physical existence which are shaped by social class, gender, ethnicity, nationality, occupation and age. They maintain that the self is both constant and responsive to change. Whereas Denzin (1989) distinguishes five forms of self; phenomenological, linguistic, material, ideological and self as desire, and maintains that the different forms of the self will always be present in any biography. Bruner (1990) adds that the self is constantly constructing, deconstructing and reconstructing, and these changes are linked to both internal and external activity. However telling others about oneself is a complex process and may involve intricate internal modifications of the narrative and narrator to suit the listener; for example tailoring the narrative to meet the expectations of the listener, based on narrator beliefs, or providing a narrative that meets the listener’s expectations of the narrator.

McAdams (2013) writes extensively about how life stories are part of the making of personal identity, these stories are made, executed and revised daily in communications with others and ourselves. While Bruner (1990) maintains that the most effective way to understand human behaviour is through people’s stories, as people create stories to explain ‘human conduct’. Furthermore McAdam (2013, p.84) adds that stories help us make sense of human lives and provide individuals with identity and a life which has meaning as well as offering a ‘flexible guide’ for the future. He acknowledges that these stories are often based on patchy and selective memories, in other words they are subjective, as remembering everything is impossible. Equally people often restructure the past in the light of the present, dates remain the same but interpretation of events may be recast. Baumeister and Newman (1994) suggest the stories people create about their experiences are both their interpretations and forms of communication with others. They maintain that stories seek to provide meaning and are rooted in a personal value system which seeks to offer justification for an action. As a consequence aspects of stories may be emphasised or

rearranged in order to explain personal conduct and intention. They go on to suggest that the stories people construct also incorporate a sense of self efficacy and enhanced self-worth and neutralize threats to their self-worth.

Therefore narrative in itself is a key attribute of the self and Erben (2000) advocates its importance for the understanding of the self, whilst Sacks (1977 cited by Rosen 1987) suggests that narratives must be told as a social act and as a performance. Meanwhile Elliott (2005) concedes that context and chronological experiences are important aspects of narrative but the meaning attributed to the experience may be more important than the accuracy of the chronological event or context, accounts may also differ dependent on the personal interpretation of the experience, which further compounds the intricacy of the concept. This complexity is further overlaid by the researcher's personal and subjective world lens which is an integral element of the interpretation process. Both experiences and personal accounts within biographical narratives will now be considered.

Experiences

The self has experiences, which involves meeting with others, involvement in relationships and events. Denzin (1989, p.33) states that problematic experiences are 'turning point moments' or 'epiphanies' or 'moments of revelation in person's life'. These epiphanies are important interactional moments offering personal or professional insight and revealing the self. They may be captured in various ways for example; rituals, writing, film, song, articles, art, drama or narrative stories. These revelatory events may be shared or individual experiences and they may be reported and recorded and made sense of in similar or different ways (Merrill and West 2009). Several of the participants describe epiphanies within their biographical narratives which relate to key moments of insight and or realisation. The insights are interpreted and given meaning based on the individuals' previous life experiences, their culture, social class, occupation, ethnicity, gender and nationality. Interpreting and making sense of something creates

understanding and learning and facilitates a shared life experience with others (Denzin 1989).

The biographical narrative of each research participant provides insight into their transition and the transformation of themselves from unsure students to confident volunteers. The changes indicate complex professional and personal transitions, enabling the identification of key health outcomes of the PBVTP. Cranton (2009, p.190) proposes that transformative learning involves individual's stories, is unique and involves seeing the self in a new and different way. The PBVPT has the potential to provide a platform for transformative learning amongst the student group.

Private Accounts

A further important aspect of telling others' stories, worthy of consideration at this stage involves the impact research may have on the researched individual or group. For example some research may divulge previously concealed material. Although this information may of course be very valuable in that it may offer greater understanding of a specific behaviour or enhance knowledge on a topic area, it is also important to recognise that the research respondent has ownership of their own information and by allowing that information to be released into the public domain may cause the individuals or group personal and professional difficulties or distress. This research captures untold stories and recognises that issues of trust, confidentially and anonymity are vital if respondents are to engage in self-disclosure. During this study participants were encouraged to make their own choices regarding the level of personal information they disclosed during their interviews, thereby giving the respondents a sense of control over the stories they shared. Atkinson (1997) advises that research participants do not ask for their stories to be interpreted and analysed, and that their stories are offered in both health care and educational settings in the hope that experiences can be shared amongst people and will be to the benefit of other people in similar situations. Furthermore Bornat and Walmsley (2008) state that not all

biographical research is empowering for individuals as much depends on the motivation and conduct of the researcher, as previously discussed. Researchers are also not acting in a counselling capacity when undertaking research and it is important to recognise that not all recollections are good and not everyone wants to remember difficult times in their lives. However Pennebaker's study (2000) recounts the personal health benefits of telling stories, a point which Richards (2008) concurs with, adding that allowing patients to talk can also offer much previously unknown information for practitioners. Telling your story also allows people to recognise and maintain contact with their history (Kaplan 1982). Furthermore McAdam (2011, p.109) maintains that the self is constantly changing and people create stories to make sense and meaning out of life experiences, while Baumeister and Newman (1994) add that these stories are exercises of self-interpretation. Moreover Atkinson (1998) remarks that although biography is not conducted for therapeutic benefits the very act of recounting a story may help people to understand or clarify an issue which has previously been unclear to them and therefore has therapeutic effects, while Shaw (1980) maintains that it enables the speaker an opportunity to order their thoughts. Bloom (1996) raises the important point that during the interview the speaker is also listening to their own story and this process encourages self-reflection, examination of representation, change and transformation. Ultimately this can lead to the development of greater self-knowledge for both the participant and the interviewer. Within my research many of the respondents commented at the end of the interview on how they had welcomed the opportunity to talk about their lives and the course. Some stated how positive the act of narrating had made them feel about themselves and their achievements, whilst others clearly looked at aspects of their lives with some sorrow and regret, although Atkinson (1998) suggests that even in these cases there are benefits. I also became part of the story telling experience and felt a great sense of privilege as I sat and listened to the participants' life stories, many of the stories involved much hardship and heartache and were very moving and I was very appreciative of the experience.

A further important issue to be considered relates to the opportunities respondents have to react to research before and after it appears in print or in the public domain. Adams (2008) writes about his experiences of writing intimate research accounts of his family and states that although all his family members are literate, they would not have the resources in terms of time, money and skill to respond to his writing in text. The conclusion to both these cases suggests that just because research respondents are silent does not necessarily mean that they are happy with the manner in which they have been represented. Clearly this is a dilemma for the researcher and I acknowledge that although I made many efforts to share the research transcripts with the participants, they did not express any interest or wish to see them or other aspects of the research. As many of the respondents had recalled difficult times in their lives I thought it was appropriate for me to be with the participants if and when they chose to read their transcripts, so I could offer help with the written English and provide or arrange for any emotional support if required. I recognised that although these biographies were owned by the respondents and resided inside their heads, actually seeing their story in print may be an unsettling experience for them. However despite frequent encouraging communication to the participants this offer was not taken up.

Using Biography in This Research

Following this discussion it is evident that there are a number of reasons for the use of biography within this study. The foremost reason was my interest in capturing the deeply personalised stories of the individuals who had completed the PBVTP, in order to understand their subjective insights and observations of the course, its methods and outcomes for them as individuals. Through this process I hoped to immerse myself in their world, to become an insider and see the world as they do. Biography values personal experiences and individuals' perspectives as insightful ways of knowing (Goodson 1997). As previously discussed Denzin (1989) recognises that in order to understand an experience it is necessary to get as close to it as

possible. Biography enables the illumination of thoughts, actions and processes whereby people make sense of, or construct, negotiate and engage with the world and also at the same time it defines a life within a chronological and social context. Another major advantage for its use within this study was its ability to access the biographies of people who would not normally have their stories documented and as a consequence, this allows insights and improved understanding of the way of life of these people. Biography also ensures that the backgrounds and experiences of the respondents are valued and their experiences and life events are grounded in their cultural and social context (Goodson 1997).

Biographical method provides a way of understanding the often hidden subjective influences within a life, according to the teller. This research was concerned with understanding the influences on and development of self-resources within the stories which the respondents chose to tell about their lives. Biography also has the ability to explore and make known the complex connections between the individual, their families, their culture and societal expectations, so as previously discussed a single biography may make known a collective way of life. This research gathers six biographies and some of the research outcomes may have implications and provide insights for a larger group, with similar characteristics.

In this research the participants present their life stories in their own style and using their own words. The insights gained from these narratives provide access to their inner world and offer a subsequent understanding of the influences on their outer world view. This knowledge was indispensable for accurate interpretation of their PBVTP experiences.

RESEARCH RIGOUR

It is accepted that logical processes and systems are required to ensure rigour within research (Ryan *et al*. 2009). For research to be trustworthy it must be methodically sound, that is it must address a number of aspects

including validity, dependability, truth, transparency and reflexivity. However Lincoln and Guba (1989) also add authenticity to ensure accurate reporting of the participants' voices. They maintain that authenticity is indicated if the research report and presentation contributes to participant understanding, empowerment and improved conditions.

The aim of this research is to demonstrate the ability of the PBVTP to provide the volunteering benefits of enhanced autonomy and self-esteem. If established these benefits will demonstrate improved conditions for this group and others in similar situations. However it is also possible to argue that the research activities enabled the participants to tell their personal stories. The very act of telling their personal life stories contributed to an increased sense of wellbeing and positive sense of self amongst the participants. Hearing and understanding the participants' biographies also enabled a clearer interpretation of their biographical narratives.

Validity

Merrill and West (2009) write that the origins of validity lie in statistical significance, standardised procedure, reliability, replication and generalisability, all of which seek to ensure that a result from a given group could not have happened by chance, could be repeated and that procedures were consistent and identical and involve no interviewer basis. However these aspects of positivist research are not valued or relevant within the interpretivst paradigm according to Butler-Kisber (2010). Nevertheless Lancy (1993) maintains that the concept of validity is central to the interpretivst paradigm, although different terms may be more appropriate. For example some researchers use credibility, or trustworthiness or authenticity, while others use reliability, transferability or truth and honesty. Silverman (2013) argues for the retention of the term validity but suggests there are different meanings. Within the positivist paradigm validity refers to the extent which an instrument measures what it is supposed to measure within the research. However in qualitative work the use of the term is more multifaceted as

researchers are also concerned with description, interpretation and participant truth telling (Holloway and Wheeler 2010). In other words the emphasis is on the provision of detailed descriptions of individual experiences and the meanings from those experiences rather than measurements (Elliott 2005). Validity is a complex term which establishes the truth, value and authenticity of a study and can be subdivided into external and internal.

Threats to validity include researcher interpretation, where researchers can impose their own meaning over the participants' stories. It is therefore important that the participant's voice, language and words are carefully listened to and used in the presentation of the research data. Holloway and Freshman (2007) advocate that researchers should adopt an empathic approach when engaging with the data to ensure that the voice of the participant is heard. To ensure internal validity Elliot (2005) observes that narrative approaches empower participants as this method allows them to set the agenda, use their own vocabulary, select the experiences to be shared, make their own subjective interpretations and provide meaning for their life events. Thereby reducing issues of fragmentation and increasing the likelihood of accurate data. This is especially the case when compared to structured interviews which impose a list of standard questions which often fail to allow individualisation of the person therefore influencing the generated data. However there is no consensus on this point as some researchers find that structured interviews provide more valid relevant data as they allow a more focused collection approach. However Kvale (1996) challenges this point stating that narratives are more concerned with the meaning that people give to their experiences, rather than the accuracy of the experience. This is frequently the case within biographical narratives which provide an understanding of people's lives within a social context rather than a totally accurate account of a historical event.

In contrast external validity relates to the ability to generalise the results of the research to other comparable situations and populations. Within the positivist paradigm generalisability is only possible if the research involves a

sufficiently large sample and adheres to a defined protocol and strict procedures to ensure that outcomes do not come about by chance (Butler-Kisber 2010). Whereas researchers working within the interpretivst field believe it is not possible to generalise results, as sample figures are normally much smaller. However this reveals the dilemma and asks why researchers engage in such research if the results have such a limited value. Or why organisations would want to fund such work. Holloway and Wheeler (2010) suggest that most researchers in this field attempt to achieve some generalisability within their work by identifying representativeness of concepts and application of theory to other settings and contexts.

However other researchers working in biography query if anything can be truly generalised when context plays such a central role to understanding (Butler- Kisber 2010). Indeed particularity, may be more relevant as in Goodley *et al*. (2004)'s work which focuses on the particular, the life of a specific person and yet the personal story resonates in a universal way with others and is able to provide authentication, knowledge and new understanding. There are also many occasions where personal biographies tell the stories of entire populations. Plummer (2001) cites the example of slaves, prisoners of war or gay men. Indeed one of the noted strengths of the biographical method is that it offers the opportunity to make known the way of life or circumstances of a given group of people, it also provides visibility and a platform for those who experience marginalisation and social exclusion (Clarke 1992). Nevertheless Guba and Lincoln (1989) maintain that the elements which underpin generalisation are important, although they prefer the term transferability. They suggest research is transferable when a rich thick description has been used and then it can be applied to other contexts and settings. This is particularly relevant now that there is widespread recognition of the data which can be produced via the biographical approach. Biography has enhanced the value of people's narratives enabling their stories to stand alone as rich descriptions of experiences or accounts to be analysed for deeper meaning, thereby further legitimatising the application and relevance of biographical data (Chamberlayne *et al*. 2000). This

research seeks to make visible the way of life and circumstances of a group of people not in education, training or employment who have successfully completed the PBVTP. The benefits accrued by this group may only be relevant to these people or certain elements may be pertinent and therefore transferable for others in similar circumstances.

Reliability is linked to validity and within qualitative research is related to the consistency of the research instrument and the ability to replicate the research results (Holloway and Wheeler 2010). However Lincoln and Guba (1989) reject the term reliability in favour of dependability within the interpretivist studies. They maintain that if the results of such studies are dependable they must be consistent and accurate. To achieve this, the work must provide a clear description of the study context and a clear audit trail throughout the research, which clearly demonstrates how the conclusions were reached. Holloway and Wheeler (2010) add that although it may not be possible to replicate such results it should be possible to repeat the study based on the provided information.

THE RESEARCH PROCESS

Choosing the research topic and group involved considerable time and reflection. As previously stated in this work I have a strong interest in the fields of health promotion and volunteering and wanted to investigate the influence of volunteering on the development of the attributes which underpin personal autonomy. After much searching and discussion with numerous organisations I selected to study the graduates of the PBVPT, with the aim of recruiting some of the students who had completed this course at a local college, where I was not known. Mindful of the potential harmful effects of ‘privilege’, I was acutely aware of my able bodied, employed, middleclass, teacher status as in contrast the group I wish to interview were unemployed, many had experienced long periods of time addicted to drugs or alcohol, many had been homeless, estranged from their families, while some had experienced mental health difficulties. As a health practitioner I had worked

and supported people suffering from mental health problems and addiction. I had also spent time volunteering with organisations which supported people with addictions. These experiences equipped me with knowledge and insight which I found invaluable when arranging meetings and follow ups with the research participants, so although I was not an insider within this group I had a familiarity with the group and a skill set, which proved helpful when communicating with the potential research respondents.

Narrative Competence

To work effectively in health care practitioners require a level of narrative competence which Charon (2008, p.1897) recognises as the 'ability to acknowledge, absorb, interpret and act on the stories and plights of others'. Clearly as a health care practitioner this process happens in a variety of ways, as people's stories can be understood at a number of levels; from the simple comprehension of the facts of a situation or event, to the factors that contributed to the event or situation, the time and setting of the story, the context of the story in terms of the person's life, the implications of the event, how and why the story was told and in some cases what elements of the story were not told. Rogers'(1980, 1991) effective and popular treatment known as person centred therapy, has been adopted by many health care practitioners, it involves providing a safe non-judgmental environment to allow the client the opportunity to develop a sense of self, so that they are able to understand the influence of their attitudes, feelings and behaviour. The practitioner uses a non-directive approach while demonstrating empathy and unconditional positive regard towards the client, aiding them to find their own solutions to their problems. Practitioners actively listen to client stories, they summarise information, clarify issues and seek client led solutions. A major aspect of working in the field as a practitioner involves dealing with issues identified by the client as being important, this contrasts sharply with researchers who frequently make their own choices as regards preferred areas of research and participant groups. In general health practitioners are actively encouraged to incorporate a reflective posture (Schon 1987) to their

practice work, which is often categorised by difficulty, uncertainly, individuality and a conflict of values. I discovered that the dilemmas and required narrative skills used in practice are not dissimilar to those required of the biographical researcher, who must also acknowledge the intersubjectivity of the research as it co-arises from the engagement of independent individuals, the social world and with the researcher's values and perspectives (Snape and Spencer 2003, p.17). Therefore as a practitioner and researcher it is imperative to minimise bias, power and privilege whilst addressing the issues of trustworthiness, paticularizability, transparency, voice, access and consent. Indeed the range of skills required for person centred care identified by Holloway (2007) are similar to those used within biographical narrative inquiry.

Interview Setting

A key factor in attendance for the participants was the location of the interview; I was able to source three different locations to suit both geographical ease and emotional comfort requirements. I soon realised that some of the initial locations I had approached to use as a venue for the interviews had historical significance and strong negative connections for some participants. Some of the buildings had previously been owned or used by the local authority or social services or various charities and were now used by different organisations, therefore I had to search out more appropriate settings. Although this process was time consuming and frustrating on occasions it had the advantage of providing venues which allowed the participants to feel comfortable and at ease. It is probable that these factors may have contributed to the quality and depth of biographical information offered during the interviews.

Although I am not a member of my research group, I have endeavoured to acknowledge and be aware of the issues surrounding privilege and power and have attempted at all stages of the research process to both acknowledge and where possible ameliorate their effects. I took great steps

to make participants feel as emotionally and physically comfortable during the research process and encouraged them to be involved at all stages of the study. I adopted a minimalistic approach during the interview, taping interviews so that I could give the participants' much nonverbal attention. I took interview notes but kept these to a minimum and ensured that the process was as unobtrusive as possible. Supplementary interview and field notes were recorded and aimed to be as accurate as possible. Interviews were transcribed as soon as possible to reduce issues of poor memory and to encourage participants to verify the transcribed narratives. During the thematic analysis the participants' voices and language were used in the theme titles and in the final presentation of the findings.

The Interview Process

An explanatory letter was sent to each participant prior to arranging the interview. When I was given the details of a possible research participant I ensured that the potential candidate had seen the explanatory letter and was happy for me to contact them. When I had confirmation of this I contacted the potential respondent by text introducing myself and suggesting several meeting times. When dates and times were confirmed the next stage was to ensure which interview location was most suitable for the candidate from their perspective. I used three different interview locations; all had similar facilities. Once this was agreed a meeting was confirmed. The interviews were held in a private room with comfortable chairs and the facility to make hot drinks. Prior to the actual interview I introduced myself, explained the format and features of the meeting and asked the candidate to sign a consent form ensuring they understood all aspects of the research and I also requested the opportunity to tape the interview and take notes, as necessary. Respondents were informed that they could stop the interview at any stage, furthermore they have full access to their interview tapes and transcriptions, then and later, and that this data would be anonymised and safely stored. They were also informed that if they disclosed something which they later regretted this information would be removed from the research.

Interview Design

Given the research difficulties already identified within this chapter I was keen to ensure that the research participants had control over the research activity, to facilitate this I restricted the interview to a single question with the aim of provoking an all-encompassing continuous flow of narration (Wengraf 2001). By adopting this position the researcher hands 'control' to the participant and assumes the position of active listener. The purpose of this design is to encourage a more natural story telling which captures personal journeys and life situations rather than a list of life achievements or sorrows. This design ensures that the speaker's narrative and how their story is told becomes fully personalised and exposed for analysis.

Participants were asked

> *'tell me about your life and how you came to enrol on the Personal Best Course and what you think the outcomes of the course are for you'*

This single question is posed and not followed up orally by the interviewer other than by helpful nonverbal communication and encouraging noises to indicate that the researcher is listening to the account (Wengraf 2001). This main narrative is continued without interruption and with no other intervention or interruption from the researcher, who adopts the position of active listener as described in research by Jones *et al*. (2011).

Really listening to someone is very demanding and tiring and takes a considerable amount of concentration. It was important for me to allow participants to include silences and pauses within their narrative accounts and not to interrupt or stop listening to the dialogue. There were occasions within the participants' narratives when they became tearful remembering previous events in their lives and other times when they talked about events that they were ashamed of and all the time I attempted to remain attentive, empathic and non-judgmental. Local counselling support information was

made available to the participants at the end of the interview; in the case that any of the participants felt they required further help and support. Note taking was kept to a minimum to avoid distracting the participant, although it was used to remark on emotional and nonverbal features of the narratives. Participants generally completed their story with a remark such as 'that's my story I don't think there is anything else I can tell you'. And at this stage we usually had a short break, followed by a second interview where follow up questions to fill any gaps on the topics already discussed were clarified. All respondents agreed to a 3rd interview if necessary. As I found the active listening within the interviews very demanding, I only conducted one interview a day, more often only one a week. Interviews varied in length from 2½ hours to 3 hours.

Ethical Considerations

Researchers have responsibilities regarding the rights and welfare of research participants and codes of conduct provide useful and practical tools to aid practice (Denzin and Lincoln 1998). Following the completion, submission and acceptance of the Ethical and Risk Assessment research paperwork at Southampton University I commenced the research and recruitment process.

Issues of anonymity, confidentiality and privacy are important factors to consider when using narrative biography as a method of data collection. A major characteristic of biographical research is that it offers a very detailed description of the respondent, so pseudonyms are used throughout this study to ensure anonymity and where necessary minor details of the respondents have been changed to prevent identification. When the research is made public it will not include the names of respondents or any information that would enable links to be made between the data and the individuals. Neither the college name nor the name of the town will be made available in the research. All research participants were informed that identities and locations would not be revealed.

At the end of the interview process the participants were reminded that the tape recording and transcribed interview would be made available to them to view and they could change or amend any aspect of their interview. They were also informed that the research would be made available to them at the end of the process. After completing the interview I wrote up notes, in an attempt to capture as wide a range of peripheral material as possible. At the end of each day or as soon after the interview as possible I reviewed the collected material in note and tape format and commenced the transcription of the tapes, which took a significant time but this process enabled me to become more conversant with the data. Research data was uploaded and stored on the university intranet, which requires a username and password to gain access. Real names were not recorded or located on the tapes, computer or files.

Although promises could be made as regards anonymity, offering total confidentially is more problematic. In this research the ideas and words of the participant are used therefore full confidentially is not possible. However if the participants disclosed any details they did not want others to know then this request has been respected. All participants were given access to my contact details so they could directly discuss or query any concerns with me. Participants were also given the contact details of my supervisor at Southampton University. This information was provided in case they felt I was not dealing with the research professionally or appropriately and they wished to discuss matters further.

Access and Consent

To qualify for inclusion within the research project all participants had to have successfully completed the Personal Best Volunteering Programme Training at the local college. Snowballing sampling was used to recruit participants, this technique has advantages when the target population is unknown or it is difficult to approach the respondents in any other way (Sarantakos 2005). I did not want the students to feel obliged to assist in the study because they

had been approached by the course leader or other college staff. I wanted the students to be comfortable in providing fellow students with information about the research and discussing their interviews with me to their fellow students. As a researcher, I acknowledged the power I could have over this study and was keen to give power to the research participants and for me to be dependent on them for their interest in the study and their willingness to take part. The participants negotiated their attendance in the research and decided upon their interview location. Following discussion with the course leader I started the process by asking her if she knew of a student who had completed the course and would be interested in talking to me and joining the research. The course leader identified an individual and following my request approached this ex-student and gave him the information about the course (see appendix 2). My mobile telephone contact details were given to the potential participant and Simon subsequently contacted me via text. We set up a meeting convenient for him and at the end of the interview, we discussed the possibility of him approaching other people, who met the research criteria and were willing to participate in the project. Simon introduced Sally who subsequently introduced Gareth and so forth. Some nine participants initially agreed to take part in the research but for various reasons six graduates of the Personal Best course were finally interviewed for the research, the remaining three were unable to commit the time and on further reflection felt unable to become involved. All participants had successfully completed the PBVTP some six to twelve months prior to the interviews taking place

DATA ANALYSIS

A major issue to concern the researcher involves interpretation of the data and the role the researcher plays in this area. Denzin (1989) suggests that although there is widespread acknowledgment that accounts need to be interpreted and that researchers have an obligation to do so, they must

always ensure that their primary obligation is to the participants rather than the research or the wider discipline.

Both Riessman (2006) and Andrews *et al*. (2008) acknowledge the wide range of diversity of interpretative approaches to narrative texts whilst Holloway and Freshwater (2007) state that this is understandable as there is a plethora of different definitions of what constitutes narrative and narrative research it is only logical that there should be a similar debate regarding the analysis of such data.

However despite the many methods of data analysis there are a number of general underpinning principles involved in the interpretation of such texts. The researcher has an obligation to analyse and interpret the many interviews within the research and to offer constructed representative themes as truthfully and honestly as possible (Denzin and Lincoln 2005). As previously discussed researchers working in this field acknowledge that multiple truths exist rather than a single truth. They need to be open to the data and aim to deconstruct the narrative, however the final write up of the research will be a construction of the data by the researcher. Although Andrews (2008, p.86) writes that it is inevitable that the researcher's interpretation of the data will change over time as varying life experiences will influence the 'framework of understanding'. In other words a new reading of the data at a later stage following different experiences may bring about a new understanding and meaning.

Thematic Analysis

This study has chosen to use thematic analysis, noted for its flexibility and capacity to provide rich, detailed and complex data whilst adopting an independent theoretical and epistemological approach, which ensures its compatibility with various paradigms (Braun and Clark 2006). Guest *et al*. (2012) believe that thematic analysis is the most useful for capturing the complexities of meaning within the data. However Green and Thorogood (2014) stipulate that a key requirement for thematic analysis is good data. It

is therefore imperative that the method of data collection generates rich information which elucidates the participants' perspectives. Thematic analysis comprises the identification and search for 'common threads' which are spread across all the data sets (DeSantis and Noel Ugarriza 2000). The themative process involves the researcher initially transcribing the interview and then immersing herself/himself in the data through rereading the transcript many times in order to gain a sense of the whole, during this activity the researcher is engaged in considering both latent and manifest content (Vaismoradi *et al.* 2013). The process aims to go beyond both a descriptive account of the phenomena and merely counting words or phrases, to focus on 'identifying implicit and explicit ideas' and patterns within the data (Guest *et al*. 2012, p.10). The researcher seeks to generate initial codes, searching for, defining and naming themes. DeSantis and Noel Ugarriza (2000, p.355) point out that the term theme is used interchangeably in the literature with a range of other terms, including category, domain, unit and phase. The term theme will be used within this work. DeSantis and Noel Ugarriza (2000) acknowledge that themes can be difficult to identify and are often very abstract, however Braun and Clarke (2006) maintain that a theme encapsulates a pattern or valuable meaning within the data related to the research question. Themes are then assembled together and through the themes the researcher identifies a story (Vaismoradi *et al.* 2013). This entire process seeks to enable understanding of the participants' meanings, including any contradictions and uncertainties (Holloway 2008).

Health care practitioners are required to practice unconditional acceptance of their clients, their stories and their situations in order to offer client centred care which is based upon the needs and requirements of the client and not the practitioner (NMC 2008). This resonates with the researchers who have an influence on the research, through interaction with the participants and also through interpretation of the data. Nightingale and Cromby (1999) acknowledge this role and encourage researchers to show how their own association with the research influences and impacts on the research.

Clearly the researcher's values and theoretical position plays a part in recognising and selecting themes.

Analysis Phases

This research follows Braun and Clarke's (2006) six phase approach to thematic analysis, where each stage requires completion prior to moving to the next.

Stage 1 involves familiarisation of the data, which demands immersion within the data. The researcher gains an in-depth knowledge of the data through repeated handling. The initial stage requires the researcher to become conversant with the data, through listening to the interview tapes and reading and rereading the transcriptions and field notes and writing notes of initial ideas as they occur. It is recommended that the researcher transcribes the verbal interview data, although this process is very time consuming and laborious it is an effective way of becoming conversant with the data. This initial process helps the generation of early codes.

Stage 2 involves generating what Braun and Clarke (2013, p121) term 'pithy labels' for significant features of the data, which have relevance to the research question or in the case of this study the research statement. Codes seek to encapsulate semantic and abstract reading of the data (see appendix 4 for an example). Erben (1998, p.9) maintains that at this stage the researcher must use imagination in the interpretation of the data. By this he means 'ability of mind to speculate upon and to link and assemble ideas related to the research text.' However he goes on to strongly pursue the idea that imagination cannot be allowed to run wild but must be anchored in the biographical texts.

In stage 3 the researcher 'codes the codes to identify similarities with the data', thereby constructing themes within the data (Braun and Clarke 2013, p.121) The phased is completed by organising codes into themes.

While stage 4 involves a review of the themes, ensuring that they fit with the coded quotations and the entire data field and a theme map is created. During this stage themes may be merged, collapsed or split.

In stage 5 the researcher refines, names and defines the themes, seeking to identify the essence of each theme. The final stage involves compiling a narrative of the analysis, which incorporates a selection of convincing and pertinent extract examples and the connection between the analysis results, the research statement and reviewed literature. As an additional trustworthiness check for coding in my study a fellow researcher, also using biographical narratives as a methodology, independently reviewed and agreed the assigned research codes on the transcripts. Although Loffe and Yardley (2004) suggest that this process does not offer total reliability as two researchers from similar backgrounds may merely apply similar subjective analysis of the data.

Reflexivity

Finlay (2003) acknowledges the centrality of the researcher, as one who actively collects, selects and interprets the data. Researchers' identities change with time and experience, these changes will influence the research process. Reflexivity provides an opportunity to openly position the researcher within the research and admit and identify their research subjectivity (Butler-Kisber 2010). So it is necessary to recognise the findings from the participant, those attributable to the researcher and the data which is co-constructed. During the research process I kept field notes which incorporated a section for reflective comments and thoughts. According to Butler-Kisber (2010, p.20) this method allows researchers to engage in an 'internal dialogue' with themselves. It encourages researchers to question, comment and keep track of issues and at the end provides an interesting historical document of the researcher's thoughts on the whole process. Researchers may include a reflective section within the study, in order to demonstrate their subjectivities. While others such as Foster and Parker

(1995) suggest the use of the first person within the completed report to recognise the active role of the researcher. I openly situate myself within this work and provide a reflexivity discussion within chapter 5.

SUMMARY

A major theme within this work relates to the requirement to capture and project the participant's voice and to find ways to guarantee that it is not lost or changed during the research procedure. Both the method of data collection and analysis were chosen to facilitative this action. Biography as a methodology provides rich and detailed data which helps researchers gain an understanding of individuals, the context of their lives and their lived experiences. In a qualitative study like this one, a critical phase within the whole research process is the method employed for data analysis. This research employs thematic analysis which sits comfortably within interpretivism. It is both flexible and transparent and absorbs the challenges of biography, which generates large amounts of data. Chapter 4 provides both the research findings and a discussion of those findings.

Chapter 4

RESEARCH FINDINGS AND DISCUSSION

INTRODUCTION

This chapter presents and discusses the collected data. The overall aim of the research is to investigate and understand the influences and benefits of the PBVTP from the participants' perspective. The two key research objectives were to explore the self-reported personal and social resources acquired by people who have completed this volunteer training, paying particular interest to self-reported assessments of self-esteem and secondly to investigate the personal perceived health and wellbeing experiences of the participants.

Prior to presenting the findings the various elements of the PBVTP will be described. This will be followed by concise biographies of the participants, which aim to provide the reader with an overview of the life experiences and challenges faced by these students. Interviews were conducted with six individuals who had attended the PBVTP. All the participants had attended the course in the same location but at different times. There were 4 men and 2 women amongst the respondents, with an age range from 25 to 52 years.

THE PBVTP

The PBVTP is a 120 hour accredited programme of learning accredited by City and Guilds, National Open College Network (NOCN), Educational Development International (EDI), 1st 4 Sport, Vocational Training Charitable Trust (VTCT) and Active IQ. It is promoted as a pre-employment programme providing a level 1 qualification in Event Volunteering. The course is aimed at 16-19 year olds who are not in employment, education or training. Or for people over 20 years who are economically inactive. The course is

advertised as a learning programme which provides support and engagement which will endure beyond the life of the programme. To encourage attendance the course and course material are offered free of charge and students are reimbursed for support costs including, childcare and travel. Lunch on college days is provided to all PBVTP students free of charge.

The course seeks to develop confidence, help students gain new transferable skills, reach their potential and improve their employability. The Personal Best graduates are encouraged to engage in further learning and employment by programme tutors. A major incentive for undertaking this course was that all successful students were guaranteed an interview for the position of Games Maker at the London 2012 Olympics and Paralympic Games. The course incorporates twenty hours of volunteering time and ten major taught units, which include:

Becoming a Volunteer – this unit of study covers preparation volunteering and the range of available volunteering opportunities. The unit aims to help the students prepare their own CVs. The students are required to successfully complete a workbook for this unit.

Customer Service – this unit covers the basics of good customer services and students are required to work their way through a unit handbook and participate in a number of relevant role play activities which incorporate customer service scenarios.

Equity and Diversity - this unit considers the diversities within populations including issues associated with fairness, stereotyping, different religious needs and requirements and disabilities. The students are required to complete a workbook on the topic and participate in role play activities which aim to aid understanding of the varied issues involving diversity which may arise whilst volunteering.

Developing Teams and Interpersonal Skills – within this unit there are a number of team work tasks including preparing a tourists “treasure hunt” and

seeking out places of interest for visitors in the local area. For example students are encouraged to research interesting historical information of the local area and format the information into question and answer activities for visitors. Students are also required to prepare a route through the local town which includes places of interest but also needs to address health and safety concerns. These team working tasks may expose interpersonal difficulties but students are expected to support each other in the resolution of any conflict or disagreements. Again students are required to successfully complete a workbook for this unit.

Preparing and Reflecting on a Volunteer Placement – within this unit the students are required to complete a work book, engage in role play activities around volunteering incidents and requirements and to complete twenty hours of event related volunteering activity. Students are encouraged to develop self-awareness skills by reflecting on their performance during their volunteering opportunities. The unit also considers interview techniques and addressing the specific requirements necessary for different volunteering placements.

Public Safety – the students complete a workbook which covers such topics as noise levels, accidents in the workplace and coping with emergencies.

Basic Fire Awareness – this unit has a workbook which addresses the basics of fire prevention and the procedures the students should adopt both in fire prevention and in an emergency fire situation.

Introduction to Conflict Resolution – within this unit the students study effective and ineffective communication and learn about the elements of conflict situations with the aim of resolution and/or prevention of problems. Again the students are required to work through a work book and engage in role play activities to secure the learning in this topic area.

Volunteering and the Olympics – in this unit the students study the history of the Olympic movement, from the ancient to the modern games and also the preparation for the London 2012 Games and its intended legacy.

During the course the students are required to visit two event venues with the intention of combining and using both the theoretical and practical learning acquired on the course.

Students are also required to make contact with the local volunteering centre in order to enlist their support for event related volunteering. They must undertake twenty hours of volunteering time in order to successfully complete the course.

The course is marketed as helping students to reach their potential within a supportive friendly learning environment. All students have access to a Personal Best Advisor as an initial point of contact for any concerns or issues that may cause a barrier to their continued course attendance or be an obstacle to learning during the course.

When students have successfully completed the PBVTP they are able to progress to other activities including:

A higher-level course at the College, such as the Access to Higher Education course

A vocational course in a chosen subject

Further volunteering opportunities

Employment

This research uses a biographical approach. It seeks to understand the influences and benefits of the PBVTP from the participants' perspective through the use of their narratives. All respondents had successfully completed the course, between six months and a year prior to this research.

The objectives of the study are to explore the self-reported personal and social resources acquired by people who have completed the PBVTP paying particular interest to self-reported assessments of self-esteem and to investigate the personal perceived health and wellbeing experiences of the participants.

Participant Profiles

In order to locate the research within context, brief biographies of the participants are provided. The information within these biographies was made available by the participants within their biographical narratives. The profiles aim to offer a succinct and personal insight into the past lives of the participants.

Simon

25 year old Simon was the youngest of all the respondents. He admits to experiencing a troubled childhood. His father escaped to the United Kingdom following imprisonment and torture in a Middle Eastern country. His parents had an arranged marriage but separated when the children were young. Simon lived with his mother and sister, although he kept in regular contact with his father, despite experiencing many distressing and emotional incidents with his father. Simon became involved in drug taking and selling illegal drugs at 14. He was addicted to heroin, ketamine and crack cocaine by the age of 19. He attempted suicide several times. Following his most serious attempt he was taken to hospital by the police. For 4 years Simon attempted to conquer his drug addiction, he spent much time as an inpatient in a number of addiction treatment centres. His biography details a number of incidents at that time which demonstrate his emotional and physical predicaments. Simon was eventually admitted to a treatment centre on the south coast and confesses that it was then that he started to face his problems. Simon's overwhelming aim was to attend university and eventually become a virologist; he feels this aspiration fuelled his willingness to change his behaviour. Whilst in the treatment centre he agreed to sign up to attend the PBVTP.

Sally

42 year old Sally was open about her unhappy childhood, she became involved with drug and alcohol in her teens. Sally suffered a mental health breakdown following the breakup of her second relationship when she was forced to live separately from her two daughters. Sally's alcohol addiction spanned nearly 20 years. Now she lives geographically close to her extended family who provide her with a great deal of social and emotion support, although this has not always been the case because of relationship difficulties caused by Sally's alcohol addiction. Although Sally lives in close proximity to her family, her home is located in an isolated setting with infrequent public transport services and little opportunities for employment. Sally left school with no qualifications, she has not worked for some time and she is not able to drive. Sally was offered volunteering opportunities on a number of occasions but was too anxious to attend any of the events. However when she heard about the PBVTP running at her local college, she agreed to join the course.

Gareth

49 year old Gareth was born in London and maintains that although he was looked after physically in his childhood, he did not feel loved as a child and young person. He has a brother. He did not enjoy school and left when he was 15 years old and started drinking at that time. He married very young and soon had a young baby. Drinking then became a major part of Gareth's life and he feels it was encouraged by his close circle of friends who were all heavy drinkers. For the next 20 years Gareth was very dependent on alcohol. Although he managed to hold down a well-paid responsible job for 15 of those years; but he was eventually sacked because of drinking while at work. Gareth maintains that his marriage failed because of his alcohol addiction. He spent many years in and out of addiction treatment centres and managed to stay free from alcohol for 2 years but then had a serious relapse when he nearly died. Last year Gareth was admitted to a treatment centre

on the south coast and during treatment he was encouraged and agreed to sign up for the PBVTP.

Jacob

39 year old Jacob admits to having a problem with alcohol and drugs from an early age. He started drinking at age 15, to boost his confidence in social settings. In his narrative he talks about the fact that he liked to drink more than other people but he did not consider this to be a problem, he often used drugs too. Jacob always managed to find work and these jobs helped to pay for his drinking and drugs. Many of the places he worked also had a strong drinking culture, with employees drinking on duty particularly during the night shift. Following a night shift Jacob would leave work in the morning and drink a bottle of vodka and then fall asleep and then go on night duty and drink another bottle of vodka. He maintains that because he was good at his job management staff would turn a blind eye to his drinking habits. Jacob lived this way for over 20 years. He eventually lost his job and his wife left him. He tried a number of times to give up and attended for treatment at many addiction treatment centres. He was eventually admitted to a behaviour therapy centre on the south coast and although he had a serious relapse 3 years ago he has not used drugs or alcohol since that time. Jacob was invited to the PBVTP following his successful treatment.

Linda

44 year old Linda states that she was not close to her family when she was growing up and was as a consequence keen to have a good relationship with her own children. Unfortunately she experienced domestic violence in her first relationship and was forced to live in a refuge with her 3 young children for a long period of time. The family were eventually rehoused but Linda was forced to rely heavily on benefits and short term part time work to make ends meet. As the children became older Linda sought out fulltime work, she worked in a variety of roles in local hotels. In her last hotel job she

experienced extensive bullying and following a bitter employment dispute, which had a major impact on her self-esteem and confidence she was hospitalised with a mental health breakdown. During the prolonged recovery period Linda was introduced to volunteering and encouraged to undertake the PBVTP.

Stuart

52 year old Stuart maintains that although he had a problem with drink and drugs from an early age he did not address the problem for over 30 years. He remembers little of his childhood. All his memories are concerned with alcohol and coping with the fall out of his extensive drinking bouts. In the past he has managed to hold down a variety of jobs but it was always difficult and for most of the time he was only employed in short term casual work. Some six years ago he first went into treatment but only managed to give up alcohol for around six weeks. Numerous visits to various treatment centres followed but with little progress. Eventually Stuart left his home town when he was offered a place at a treatment centre on the south coast. Stuart believes that leaving his home was the best thing he could have done, he was no longer mixing with his old drinking friends and living in a new location meant he could make a new life for himself. He was initially successful on the treatment programme and soon was on a college course and working for cash in hand. Unfortunately following a visit back to his home town he started drinking again. The relapse left him homeless and soon he was sleeping rough on the bandstand by the sea front drinking to block out the cold, the negative feelings and the shame. However within a few months he was living in a half-way house and after a few difficult months he was admitted back into treatment. Following successful treatment and involvement in local volunteering Stuart was encouraged and agreed to enrol and complete the PBVTP.

Organising and Interpreting the Data

Prior to considering the research findings the thematic analysis process used to derive the themes will be discussed. As previously discussed the six phase analysis process described by Braun and Clarke (2013) was used in this study. I transcribed each interview as soon after the event as possible. The transcriptions were reread many times, in order to achieve immersion and familiarisation with the data and to gain a sense of the whole biography. Then the entire data set was coded, during this process I applied, where possible, short concise terms to summarise the descriptive aspects, both explicit and implicit and underlying features which were theoretically supported. Numerous codes were created at this stage. Figure 4 provides an extract from an interview to demonstrate initial coding. Further examples of coded text from the participants' biographies are available in appendix 4.

Figure 4: Example of coding from participant biography

The transcripts were then reread to review the overall coding. At this stage some codes were changed, added or modified to ensure consistency across the data set. For example codes which had similar meanings were merged, although some codes which were vague or lacked precision in their meaning

were split. See figure 5 for an example of codes which were modified and merged into one code.

Initial Codes	Reviewed Codes
did well	success
achievement	success
success	success
attainment	success
recognition from others	acknowledgement
reward	reward
proficient	skills
ability	skills
recognition of self	Self-belief
skills	skills
acknowledgement	acknowledgement
worked hard	tried
talent	skills
completion	success
positive	self-belief
incentive	reward
praise	acknowledgement

Figure 5: Illustration of code review

The next stage involved identifying and constructing themes from the codes whilst always being aware of the research statement. Pertinent data was organised within each theme and the data sets were revisited to ensure that the developed themes contained and captured an understanding of the participants' experiences and outlooks. A number of themes were constructed and refined. During the review process the themes naturally fell into two major themes, the individual and the development of personal self-resources and the growth of beyond the person resources. I called these themes Self-Resources and Wider Personal Resources. Within each major theme a number of associated themes were grouped. Figure 6 shows the two major themes and their associated themes.

Self-Resources	Wider Personal Resources
Feeling good	Meeting new people
Managing anxiety	Helping people
Capabilities	Doing new things
Pride in appearance	
Looking after myself	

Figure 6: Research themes and associated themes

As can be seen from figure 6 *Feeling good* is an associated subtheme within the major theme *Self-Resources*.

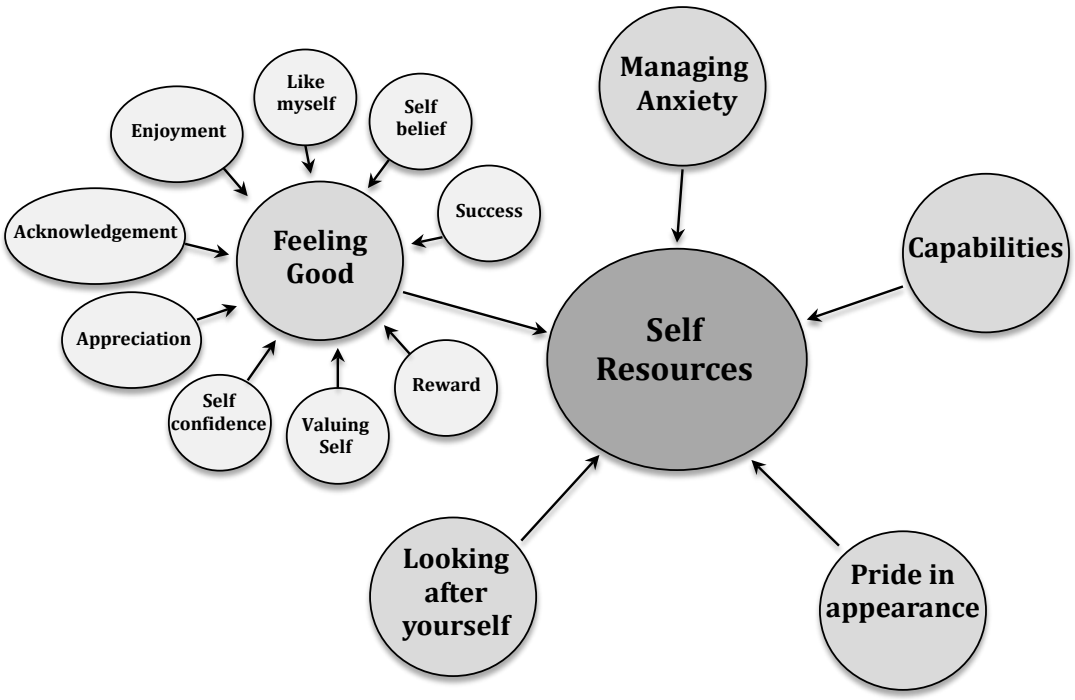

Figure 7: Example of the coding underpinning the associated subtheme 'feeling good' and its links to the major theme 'self-resources'

Figure 7 provides an illustration of the relationship between the major theme; Self-Resources and its associated subthemes. It also demonstrates in diagram format how the devised codes underpin and make up the associated subtheme ‘feeling good’.

The findings which now follow seek to illustrate and illuminate what Hollway and Jefferson (2000) refer to as the inner world of the respondent. This work acknowledges that researchers cannot know better than the respondents who speak about their lives. Therefore results are presented using the respondents’ words taken from their transcripts and centre upon the experiences of six people who successfully completed the PBVTP. Although the individual biographies are unique there are several commonalities between and within the participants’ narratives.

Self-Resources

As previously acknowledged in this work, there are a number of self-resources which underpin personal autonomy. Childhood is viewed as an important stage in life for the development of these resources (Weare 2000). However a recurring theme amongst the participants’ narratives relates to their troubled childhoods and the early attraction of drugs and alcohol which helped them feel better about themselves. Several of the participants talk about not feeling loved as a child or a feeling of being unsupported and not valued. The participants’ profiles demonstrate long periods of unhappiness, addiction to drugs or alcohol or mental health problems. Many speak of their lack of motivation or inability to maintain relationships or attend school or engage in employment during these difficult periods. The participants were referred for the PBVTP by a number of agencies including the mental health and addiction services. To access a place on the course the participants had to meet the criteria of not being in employment, training or education. All participants agreed to attend the PBVTP on a voluntary basis and all of the narratives identify the development of self-resources during and post the PBVTP. Within this section evidence is offered from the participants’

narratives on over-coming anxiety, feeling good, capabilities, pride in appearance and thinking about health. These aspects of self are discussed with links to relevant literature, however as previously stated in this work most of the volunteer studies to date have not considered volunteers not in education, employment or training, which indicates that comparisons may be of interest but have limited value.

Feeling Good

The PBVTP provides a range of teaching and learning opportunities, including role play of possible volunteering scenarios to gain direct experience. The course provided information and advice on dealing with the general public and included theoretical and practical sessions on stress management techniques. Vicarious learning was achieved by watching others model appropriate behaviour in response to routine and challenging scenarios. As the narratives progress the respondents identify a number of positive personal attributes which they gained as a result of attending the PBVTP, including improved self-confidence and self-esteem. Positive comments on enhanced self-esteem and self-confidence were universal to all participants.

My self-confidence and my self-belief just grew again
(Stuart)

The PBVTP required all students to regularly attend the course, they also had to be punctual, appropriately attired, and willing to contribute and engage in all timetabled activities. As students they had to actively participate in all aspects of the course, including class and group discussions where their opinions and ideas were essential to the activities. Many of the practical tasks involved collaborative working, where students were encouraged to communicate their ideas effectively and learn to actively listen to others. In the past many of the participants would have avoided this type of activity but most of the participants engaged in the debates and felt stimulated to query traditions, openly examine evidence, question arguments

and offer different points of view. They were also personally challenged to participate in a wide range of activities including; public speaking, role play activities, complete maths and English qualifications, reading, writing and listening work, communicate and engage with external agencies, volunteer at large and small local events and work in groups to organise events. Some of these challenges were considered to be monumental by the students and their feelings of satisfaction and pride at being part of the group and accomplishing positive outcomes gave the students a strong sense of achievement and wellbeing.

> *The Personal Best course helped my confidence so much. I can't explain it, being with a lot of people again and that was difficult ……definitely confidence , how they put it together and made you feel good, some things were you know seemed strange and peculiar but it all made sense when you finished the course (Linda)*

Sally's narrative reports a long period of alcohol addiction and aimless unhappy days, where she spent most of the time in her home often lying in bed. She reports high levels of anxiety and feeling overwhelmed by attempting any task, especially when it involved people that she did not know. Following treatment for alcohol addiction she agreed to attend the PBVTP and the activities within the course provided a platform to facilitate the development of her self-confidence and self-belief. Bandura's (1977, 1985) work on self-efficacy shows its importance for the development of internal resources and consequent behaviour change. Sally's confidence and self-belief were so improved that she was able to take the lead and co-ordinate the organisation of refreshments at a local volunteering event; she was pleased to report these changes but was also surprised at her own ability.

> *this is all the things I've gained from the Personal Best course through volunteering because it's just given*

me the confidence. I (at an event) made the tea and coffee but I couldn't have done that a few years ago. A few years ago I couldn't even get out of bed (Sally)

Communicating to 'normal' people was problematic for many of the participants. They repeatedly raised the issue in their narratives and maintained that they had little in common with other people who had not experienced drug or alcohol addiction or mental health problems. In their narratives they used the term '*normal people'* for people who did not share these experiences; they felt they had few shared experiences and little to talk about. This often made them feel outsiders as they felt they did not have the ability or knowledge of everyday life to engage in routine 'small talk'. The participants' past experiences set them apart, by shaping every aspect of them as human beings; their physical bodies, appearance, self-confidence, self-esteem, language and the content of their conversations. This had a number of effects, not only did it exclude their entry into other groups (Lee and Brudney 2009) but it also encouraged them to isolate themselves further. These negative feelings were further combined with their already diminished sense of self and poor self-esteem. Davies and Macdowall (2006) acknowledge the importance of interpersonal skills for developing and sustaining human relationships and that communication between people requires personal management. In order to help the development and attainment of such skills the PBVTP offered opportunities for regular, safe, in-house communication practice sessions prior to volunteering at events. Although many of the students found these sessions and the real encounters with the general public challenging, they acknowledge that although the process was slow, it was valuable in helping the development of their communication abilities.

To get confidence you have to do things you don't want to do on the Personal Best course you have to talk to people, act normal tell them where to go. You are forced to do

things you don't want to do, you do it well and then you feel better about yourself and you are building up your social skills and you start to feel you are worth it – you start thinking I am important and it builds you up step by step *(Simon)*

The participants felt the PBVTP provided other opportunities to feel comfortable and enjoy themselves. However in the past many of the participants had used drugs and alcohol to make them feel good, experiences within the PBVTP helped to show them that there were other ways to achieve happiness, for example; taking part in enjoyable activities, being physically active, smiling and laughing more often (Weare 2000). Humour naturally played an important role in all the PBVTP activities and was greatly valued and commented upon by the participants.

We always had a good laugh and we used to do role-play. Role-play that's a confidence builder doing it in a group (smiles at the memory of the activity)
(Gareth)

Within their narratives the participants talk about the importance of praise in their personal development. Many of the participants had experienced unhappy childhoods and poor learning opportunities at school and had little experience of praise. Weare (2000) writes that there are a number of practical methods for helping people become autonomous, including proactive and energetic educational methods, which aim to tackle the forces which prevent autonomy. Rogers (1983) favours experiential learning methods through either individual or group work. He proposes that the sense of self is central to all forms of learning and people will only engage in learning if they feel it is beneficial to the creation or preservation of their sense of self, when learning threatens the self it will be blocked. The PBVTP

offered provided positive learning experiences which were very different from many of the participants' memories of learning in school.

> *When people tell you, you are working really well you want to keep doing it – they said that on the Personal Best course and that helps your confidence and people saying thank you it helps how you feel about yourself.* *(Gareth)*

The use of genuine praise in a supportive environment is seen to be important to learning (Weare 2000). Over time the narratives indicate an increasing belief in themselves and their ability to master skills.

> *Sometimes I get nervous but when people say you have done a good job and they smile and say thank you it makes me feel good* (Jacob)

Frequently the participant biographies refer to the self. As the students' progress through the PBVTP there is evidence within their narratives that they are reconstructing a new sense of self, which Bruner (1991) maintains is a constant process, while Gergen and Gergen (1988) stress the importance of experiences for the social construction of the self. Simon's comments on 'liking himself' are common to many of the narratives at this stage. Brown (1998) proposes that the Me-self, which is part of the duality of the self, focuses on who the person is and what others think of them. Therefore when the participants received praise and encouraging feedback from peers and other valued sources it positively influences their Me-self, which successively shapes their self-concept.

because you do it to help yourself. I like myself now I have a good opinion of myself not like before and all the stuff that has come after the Personal Best course (Simon)

The PBVTP offered opportunities for the participants to receive positive feedback for their learning and activities. Praise, appreciation and encouraging comments of their actions helped to reduce the discrepancy between their idea of their real-self and their ideal self. This according to Harter (1999) enhances self-esteem and contributes towards what the participants termed 'feeling good'.

Managing Anxiety

Previously this work acknowledged Mann *et al*.'s (2004) work on the multiple outcomes of low self-esteem, which demonstrates the link between low self-esteem and mental health conditions, social problems and risky behaviour. All of these consequences are evident within the participants' biographies, which make reference to, amongst other concerns, generalised feelings of anxiety; lack of confidence, low self-esteem and self-doubt. For many, these feelings were accentuated prior to commencement of the course and some were particularly apprehensive on the first days. For some participants the biggest initial hurdle was walking into a room full of people they did not know, for others it was going back into a class room, an arena that held childhood memories of failure. All of the participants had left school at the earliest opportunity. Many confessed that several of their acquaintances had planned to attend the course but were unable to attend the start of the course because of overwhelming anxiety and therefore were unable to take advantage of the PBVTP. Others like Linda had to have someone offer physical and emotional support to help her into the college building.

She (support worker) went with me, cos I was too scared to go into the building on my own……when I

got into the course obviously I was very quiet, very quiet, just crying every day and such before I went in. I did try to give myself a pat when I came out because I did achieve something even if it is just walking into the building *(Linda)*

Jacob confessed to being very apprehensive prior to the start of the course and his comments on nervousness were common to the other participants.

I was very nervous at first and of course I was with a lot of strangers. ….I found the first few days very hard but soon I wanted to go and looked forward to going *(Jacob)*

The course leader and the activities within the course aimed to put the students at ease from an early stage. There were a considerable number of confidence boosting icebreaker activities and frequent 'smoke' breaks. However within a short number of sessions, there was an expectation that the students would actively become involved in the learning by forming small groups and working collectively to complete various tasks. Teaching and learning modes were different from their school experiences and for some students the group exercises were very challenging and initially caused apprehension. Many of the participants' school memories depict a picture of unhappiness and limited learning achievements and much of their emotional anxiety has origins in their negative educational experiences. As a consequence of missing learning opportunities at school, they felt vulnerable, inadequate and unsure at times. Many of the respondents preferred not to draw attention to themselves in the group activities; they attempted to stay in the background and tried to reduce their visibility to and within the group. At the start of the course some felt that their contributions would not be valued

or recognised, for many it took tremendous courage to answer questions or give opinions in front of others.

> *If you've got no confidence it's the hardest thing to do - speak out in amongst a group of people* *(Linda)*

The participants expressed concern that they would look foolish or respond with incorrect answers. These adverse feelings appeared to resonate strongly with previous negative school experiences.

> *It has been scary…. The really scary (missing word) was the Personal Best Course, that was the one that got at me because it was like I'm going back to school and my biggest fear was people thinking, oh she's so thick, she's so stupid she won't know what she's doing* *(Sally)*

However although the participants experienced much anxiety at the start of the PBVTP their narratives soon became more optimistic as they slowly settled into the course and became more confident. As the course progressed the students became more actively involved in the process and began to enjoy the different teaching and learning styles.

<u>Capabilities</u>

The planned activities on the PBVTP provided a platform to reveal and develop personal qualities and attributes, many of which were previously unknown to the participants. Sally's comments show that the volunteering provided her with insight and appreciation of her own abilities to engage in a wide range of activities. This knowledge contributed to an improved sense of personal worth and a positive belief in herself.

> *I've done all sorts (*referring to different types of volunteering*).*

It just gives you that sense of this is what I am capable

of and this is what I can do and I can do it well and

I'm confident it just builds you (Sally)

As the participants became more self-assured in their own abilities they also became more confident and began to demonstrate a determination and problem solving attitude to difficulties. Some like Garth commented on this change of attitude acknowledging that in the past when things became difficult he would quickly abandon the task.

if things didn't work out initially we would try something

else – in the past I would just throw the towel in and

walk away (Gareth)

Many of the participants comment on the support they gained from others in the group. Lin (2001) maintains that individual social capital is the pool of resources which an individual can draw upon, although the range and variety of resources will differ between people. In the case of the participants they were able to call upon the support of others on the course. In time their networks increased to include not only current students but also teaching staff, staff at the volunteer centre, previous PBVTP graduates who use the volunteer centre and other volunteers from their volunteering activities within the locality.

sometimes the course was very hard but having

lots of people to solve a problem really helped.

We shared our ideas. (Linda)

Linda's comment makes a relevant link to the work of Putnam, (2000) who advocates that social capital enables people to work co-operatively in an effort to resolve shared problems. By working collectively group members were able to share their other networks, knowledge and skills for the benefit of the whole group and the participants recognised that their capabilities were multiplied when they worked together. Putnam also proposes that social capital helps people to become both trusting and trustworthy. Many of the participants discuss trust in their narratives when they refer back to darker times when they were homeless, or in hostels or friendless. Frequently they were not viewed as trustworthy by others, such as family members, the general public and the police and equally they did not trust the other people they slept rough with or the other inhabitants of the hostels. So although the participants were members of different groups in their past lives the resources they gained from these groups were very limited in comparison to the resources they enjoyed as PBVTP students.

Pride in Appearance

The positive changes the participants' catalogue within both their emotional wellbeing and belief in their own abilities is mirrored in the care and attention they began to bestow on their physical bodies. Narratives include comments on their personal appearance and report a sense of personal pride in how they outwardly appear. They describe taking more care with their personal hygiene and a desire to wear clean clothing. This is in marked contrast to their previous lives when clothes and cleanliness were not important factors. The embodied feelings of failure and poor self-worth were supplanted by feelings of pride in their appearance provoked by a belief in their own self-worth and improved self-esteem.

> *Since the Personal Best course and doing the volunteering I think about myself and I always wear clean clothes and make sure I have washed and*

shaved. I make sure I look Ok. What a difference,

for years it was never important to me (Gareth)

The course and the volunteering made me think about

what I wore and making sure my clothes were clean

and tidy, I hadn't thought about those sort of things

in ages (Jacob)

These caring feelings were not just restricted to the outer clothing and appearance of their bodies but also motivated the participants to take an interest in their physical health.

Looking after Myself

As the participants began to believe in and value themselves more they became more concerned and interested in understanding and caring for their human bodies. Many of them express an eagerness to improve their knowledge about their bodies and also a desire to care for their physical health. Linda voices concerns about her food and wishes to change her diet to include more healthy food which she recognises as being better for her body.

Since I've done the course I'm actually looking after myself

better, from the inside as well as the outside. I want to be

healthy, I want to get more healthy food inside me and

that's 'cos my eating habits aren't too brilliant (Linda)

Simon's comments also indicate how he now wants to care for his body. His dialogue identifies a cleansing process for his physical body as he aims to rid it of all the negative consequences of his past addiction and feelings of inadequacies. He seeks to wash away the past by physically embodying the new ideals which reflect his changed values, attitudes and beliefs.

> *Volunteering was the complete opposite, putting in time for free. And putting other people first and now this makes me want to be healthy: I quit smoking and wanted my skin to be smooth. Volunteering kinda of I don't know – it's hard to explain. You know when you go to the sauna and sweat and you feel like all the crap comes out of you – well it's like that all the horrid stuff is coming out of my body physically. When I started to do the volunteering I started to buy face cream, making sure I didn't smoke, working harder to stay alive* (Simon)

The PBVTP does not engage in any health promotion or public health work and yet the participants comments indicate that one of the benefits of the course seem to be an increased interest in improving their personal physical health and wellbeing. Musick and Wilson (2008) suggest that volunteering promotes the quantity, variation and diversity of personal social connections which influences physical health by protecting against illness and prolonging life. THE PBVTP provided the participants with opportunities through volunteering and group activities to earn respect from others, which promoted their self-esteem, belief in themselves and contributed towards the development of personal autonomy. As previously discussed Marmot's (2003) work stresses the importance of autonomy for achieving good health

and his work actively advocates that people should seek autonomy as a way of attaining good health.

The evidence presented within this theme suggests that the participants gained a range of self-resources and experienced an improvement in wellbeing. Volunteering involves helping other people and as a consequence it changed the way the participants thought about themselves. Work by Wuthnow (1991) states that volunteers are rewarded with appreciation and social recognition, which positively influences their self-concept. The participants also found that volunteering provided a framework for their day; it gave participants something to plan for and look forward to and kept them active. Similarly their volunteering experiences offered a medium for the development of skills and attributes, which they found fulfilling and gratifying. This further enhanced their self-esteem, self-confidence and feeling of control over the environment. As previously discussed Laverack (2005,p.40) highlights that self-confidence and self-esteem are key characteristics of the empowered individual, as individuals become more powerful through their own sense of worth. The participants' also recognised their positive impact on the community and other people's lives, Piliavin (2002) suggest this further enhances self-efficacy and improves mental health and these attributes contribute towards the actualisation of personal autonomy.

Wider Personal Resources

A further objective of this research was to explore the broader personal resources gained by the participants as a result of completing the PBVTP. This theme identifies the evidence and discusses 'making connections' and 'being open to opportunities' and 'helping people'.

Meeting New People

Although the participants were all interviewed individually and gave personal and separate narratives there is an element of collective experience and

solidarity within their spoken words. The learning they benefitted from was both at an individual level and as members of a cohesive group. Participants were interconnected because of their previous shared experiences and this was augmented by development of relationships which were required to complete the PBVTP group tasks. The participants frequently use the term *we* when relating PBVTP experiences.

Despite their early concerns the participants soon gained the confidence to initiate connections with others on the course. During the team working activities they had to work together to seek solutions to organised tasks. Many of the PBVTP activities are underpinned by active learning techniques, which encourage the students to collaborate and discuss in order to achieve set tasks. Within their narratives the participants identify an improvement in their ability to develop and maintain personal relationships; they also observe how much they enjoyed other people's company, which they felt contributed towards a feeling of positive wellbeing and happiness.

> *We walked around the pavilion and we had a choice*
> *and our group did a treasure trail for children, not actually*
> *did but a scenario and we had to make directions and a*
> *little map of all the places the children would go and*
> *what stops and landmarks they would stop at and we*
> *all had a little role in that, but we all got given a role,*
> *but funny enough at the end of it we all got given our roles*
> *which we all put together and just mucked in together*
> *if you see what I mean it just worked out better that way.*
> *But we did have fun, we really did have fun. (laughs)* *(Sally)*

Group activities provided an opportunity for interpersonal learning and the feedback sessions helped students develop their personal perceptions, which enabled self-awareness and an appreciation of their impact on others in the group. Through this process students also developed a greater awareness and understanding of themselves and the other personalities within the group. This route encouraged enhanced group cohesion and the growth of firm social bonds. However these students also had a shared background. All of the participants' biographies identify the importance of having other people like themselves within the group. This seems to be a major factor in facilitating the early development of positive personal relationship and good group dynamics. The participants understood each other's circumstances and were aware of the difficulties other group members had faced. This gave them a common understanding and social language, which encouraged them to provide mutual support and help to each other. The students shared coffee breaks and met socially outside of the college as well as engaging in PBVTP tasks and volunteering. All the students spoke warmly of the support they gained from others in the group. The mutual trust and group cohesion enabled the students to actively engage in team working in an attempt to seek well informed solutions to posed volunteering problems. All of the students commented favourably on group activities, for many learning was enjoyable for the first time.

> *we did quite a lot of group stuff working out things,*
> *after a while I really enjoyed the stuff we did. I*
> *got to know the people and felt really good* (Jacob)

> *We learnt to work as a team, basically we learnt to work*
> *together. It wasn't singled out, we were all together and*
> *we helped each other out together, we did our work together* (Sally)

Although some of the participants admitted that sometimes group work was challenging and on occasions events made them angry, but their improved communication skills and the use of humour appeared to help them find a way of working through their difficulties.

> *Sometimes I got cross in the group work, I didn't always agree with the others, but we usually found a way and we always had a laugh (nods head)* (Stuart)

Volunteering provided a link to the wider social world for all the participants. Although this was initially troublesome as many only felt comfortable talking to people in their own social groups. However volunteering requires people to work with other volunteers and members of the general public, where social exchanges are mostly sincere and positive (Musick and Wilson 2008). Working together and helping each other involved frequent exchanges which the participants acknowledged improved their interpersonal skills, enhanced mutual trust and gave them a sense of belonging and social satisfaction. As previously acknowledged in this work Marmot (2006) advocates social participation as a key instrument for both healthy individuals and healthy communities.

The membership and learning within the PBVTP provided a platform for the students to initially develop a wide range of personal resources and skills and then further extend these skills during volunteering opportunities.

Helping People

The participants' biographies demonstrate a change in their willingness to engage in volunteering. In the past many of them were approached to become involved but their narratives indicate that prior to attendance on the PBVTP volunteering was not something they wanted to do. Mainly because they did not see it as a valued activity and also because mixing with people outside their 'own group' was difficult for them. As previously stated Musick

and Wilson (2008) maintain that education is the strongest forecaster of volunteering. All of the study participants left school at an early stage, without securing qualifications, however it is probable that attendance on the PBVTP enabled an appreciation of the benefits of volunteering both for themselves and for others. Furthermore as a result of the PBVTP all the participants spoke about a new enthusiasm to give something back to the community which had helped them and a willingness to aid the community in whatever way was required. Following completion of the PBVTP all of the participants were actively engaged in volunteering activities, both formal and or informal.

> *When I was in treatment I saw other people come back and do volunteer work and I could not understand it. I used to dread it every day – it was only for 1 ½ hours each day, I just couldn't understand why people would come back every day to come from where they lived to do this. Perhaps its because I'm not being forced to do it….I don't know but it feels nice to (be) one of those people that can go back and do volunteer work and help and maybe someone else will look out of the window and think how can you come back and do that* (Simon)

Low *et al*.'s (2007) research on what motivates volunteering ranks '*giving something back'* very low, however many mainstream volunteers engage in volunteering with groups or organisations which have helped them or a family member or a friend. In the case of the participants they felt a sense of loyalty to the local community which they felt had given them so much. Many had benefitted from both medical and rehabilitation treatment services and several of the participants had been rehoused in local authority housing.

My community has done so much for me, this is my chance to do things for my community (Sally)

In general the participants identify similar volunteering benefits as mainstream volunteers echoing the survey compiled by Low *et al*. (2007) which indicates that most people are positive about their volunteering experiences.

I generally like helping people you know. I like people and the feeling that you get its rewarding but it's like a different type of reward, it's not money it comes from inside you. (Linda)

When the participants were volunteering they were frequently thanked for their efforts by members of the general public and people involved in organising the events. Receiving these positive comments had a major uplifting effort on the moral of the participants, who felt that in the past they had been either invisible, ignored or snubbed by the general public.

During the course we did some volunteering, I was a bit unsure at first but then really got into it. People were just so nice to me. They thanked me for my help, not everyone but somehow I managed to be polite when some people were a bit rude or stuff. Soon I couldn't wait to go volunteering. I just felt so good my confidence really got better and I managed to talk to complete strangers without worrying (Jacob)

Participant narratives demonstrate changes in attitude towards a greater sense of social responsibility and volunteer satisfaction when helping other people. They also show a strong sense of community belonging and a desire to reciprocate the support offered by the local community. Musick and Wilson (2008) acknowledge similar findings.

Following the PBVTP several participants were motivated to share their volunteering experiences with other groups. They recognised that undertaking the course and becoming involved in volunteering had provided them with multiple benefits and they were keen to share this information. However for many there were extensive personal costs involved in sharing the information. For example Simon went into the local prison to talk about the PBVTP and volunteering. Although he was very anxious prior to the visit and fully expected not to be well received, he was keen that his new skills could be put to good use and that other people in difficult circumstances had the chance to learn about the benefits of volunteering.

> *I was asked to go to the prison and talk about how volunteering can change your life. I went and talked all about it, one of them was proper interested. But others said I'm not working for free. Which I expected I even expected to get things thrown at me but instead they all listened really well and one of them came up to me and said you have inspired me to change my life and that felt amazing. When he said that to me it increased my self-worth. It's almost as if all these people were waiting for me to get better to come and help them. But it took a lot of courage to go and speak in the prison, one of the first things we did on the Personal Best Course was to*

talk on anything in front of the class and before I did
it I was really worried about it, I didn't sleep, I couldn't
speak at first I was so worried…I felt amazing afterwards. (Simon)

A positive sense of community and sharing was also evident amongst and between the participants, they looked out for each other and had a concern for the continuation of the course and the future of the local volunteer centre. Although the PBVTP had originally been designed to increase the numbers of volunteers for the Olympics the participants thought the personal rewards of the course were so valuable that the course should have a life outside of preparing volunteers for the Olympics.

I know it was only supposed to be running for the Olympics
but I honestly truly think if it's helped me and all the other
people it's got to keep running not just for the Olympics,
that's the one thing I would love to do to make sure it
keeps running (Linda)

Without the course and the support of the local volunteer centre it is very unlikely that the participants would have become involved in volunteering. Following completion of the course the participants recognised the personal benefits of the course and were anxious that its benefits were extended to others.

I hope the course doesn't not stop after the Olympics
Because we need something like this running all the time
to help some people (Sally)

All the participants had close connections with the volunteer centre in the local town. They met in the offices on a regular bias, where they were well known to the staff. The staff organised and listed volunteering opportunities, recruited volunteers and provided a location to enable the group to support each other. This supports the work of Lee and Brudney (2009) who found that socially excluded people are unlikely to be connected to groups who are asked to volunteer unless policies or strategies were specifically set up to encourage them. All of the participants were concerned about the future of the volunteer centre. Although the centre was active in fund raising towards its own costs it was having difficulty paying its way. The participants valued both the PBVTP and volunteer centre and were keen to support and publicise how significant these services had been both to their lives and the wider community.

> *They don't know how much longer it is going to be open for as they are running out of funds rapidly and all, it would be a shame because it has been a god send for so many people* (Sally)

Participants were also actively involved in organising a range of fund raising activities to support the centre.

> *I've also had an idea about a travelling workshop which you know that would be quite a good thing for the kids and adults and the money would be put towards the volunteer service because I know they are struggling* (Linda)

The extracts from the participant narratives indicate the development of social relationships, a concern for the local community and key features of social capital. Gottlieb and McLeroy (1992) document a number of studies which indicate the relationship between social relationships and social support and its protection against ill health. While Mittelmark (1999, p.447) maintains that the benefits of stronger social ties are 'better-functioning individuals, families, neighbourhoods and work groups and improved physical and mental health'. He suggests that social ties influence health by

- Provision of information to help avoid stressful or high risk situations
- Increased feelings of self-esteem, self-identity and control over the environment
- Social control, social regulation and normative influences
- Sources of real support
- Sources of emotional support
- Belief that support is available
- The cushioning actions of others in times of stress

Campbell *et al*.'s (1999) work suggests that the social capital constructs of trust and civic engagement are particularly relevant to health status. High levels of trust are associated with lower mortality rates and higher rates of reported good health. Within their narratives the participants spoke of their increased circle of friends gained through the PBVTP and how much pleasure and support they gained from this group of people. The support was multi-fold in that it offered social, emotional and practical help as well as a network for sources of information and the exchange of news.

Doing New Things

Within their narratives the participants placed strong emphasis on the new opportunities the course has opened up for them. They expressed a feeling that the course had enabled them to be more open to changes within themselves, helping them feel more capable and willing to accept new

challenges. The participants attributed a range of other learning aspects to the PBVTP, including skills and knowledge for the workplace, qualifications in key subjects required for employment, interpersonal skills and a desire and motivation to continue to learn and achieve. The opportunities opened to the participants were wide and diverse. Many of them talked about their improved relationships and life and work prospects following their experiences on the course. A general air of positivity is evident at this stage of their narratives.

44 year old Linda left school with poor memories of her learning abilities and no qualifications. While on the PBVTP she was encouraged and finally persuaded to undertake qualifications in both English and Maths, which she successfully completed.

> *on the course we did lots of thing but when she said to me about doing maths, I actually hid for ages. I thought I can't do it……but she kept on at me and I passed level 1 and 2 English and level 1 Maths.* (Linda)

Jacob aims to become a plumber. He believes that undertaking the PBVTP and doing volunteering has helped him become more resilient and determined to '*see things through'*. As part of his plumbing course he was required to find a plumber who would offer him a practical placement for the duration of his course. Sourcing someone who would offer him such an opportunity proved challenging but Jacob eventually succeeded and continues with his course.

> *I started to do a plumbing course last year. I've got a long way to go but I'll keep at it, my dream is to work for a company as a plumber. If I hadn't done the Personal*

Best course and the volunteering I don't think I would have stuck the course. I had to go out and find a plumber to work with and the PB course gave me the courage to talk to people. I wasn't easy but I did it. I found someone who has taken me on for 1 day a week to get some experience (Jacob)

Simon the youngest participant has a dream of working as a virologist. He left school with few qualifications and therefore in order to access his university course he had to equip himself with a range of relevant qualifications. He has been successful and holds a university place.

Yeah I am going to university in September I have been accepted to do microbiology which is cool. Which is mad because 2 years ago I couldn't even tidy my room I was sat in my room watching telly and doing drugs. Yeah and now I am going to university I know it's going to be hard going to university being around normal people (Simon)

42 year old Sally has experienced long periods of anxiety. Prior to the PBVTP she spent most of her time at home either in bed or watching television. After much persuasion by a social worker she agreed to attend the group's annual camping trip. In her narrative she describes her feelings about the trip and what culminates into a major event in her life or an epiphany as Denzin (1989) would term it. Sally's narrative is a social performance (Sacks1977 cited by Rosen 1987) which describes and explains her actions through her self-dialogue. I have read and reread Sally's biography many times and it appears to me that the challenges and achievements within her camping trip narrative mirror her many personal

development changes both during and since her attendance on the PBVTP. Within the narrative Sally physically embodies her feelings of isolation, loneliness and fear which give way to joy and triumph as she succeeds in controlling and overcoming her anxieties.

> *every year they have an annual camping trip at (names a treatment centre) and I said no, there's no way you won't get me camping, I said I will be dirty, I can't have a bath it will be really horrible. Well after they all raved on about it for weeks and weeks, I eventually thought Sally you have never been camping in your life and I thought why don't you just give it a try? So they talked me into it and for about a week before I thought I'll do it, I won't do it and they eventually got me there. Well, it was the most amazing three days of my life we had. I can't swim, I live in (names location) by plenty of beaches but I cannot swim, I'm scared of water. Well one of our things was kayaking. So we went kayaking and we were sat in a group and there was two young lads instructing us in a group in (names location) and I thought this is why you're here and you've got to try these things instead of wimping out and you've got to give it a go and if you can't you can't and I'm sat on this rock looking at the kayak shaking. And I got in it and because it was shallow the Kayak was going like that with me in it and I was saying get me out, I don't like it I'm scared, get me out and the instructor turned around and said you're not getting out, everyone*

else is out there, come on. Because, they obviously knew where we were from and that. So I paddled out to the middle of the water and I was stiff I mean I was like a robot and I couldn't move and I thought if this boat moves I'm going to go in the water and I'm going to panic and I did it. I rode my little Kayak all round (names location) and I loved it and then after that we got in a big canoe and we were weaving in and out of rocks and things all round (names location) and I loved it and when I got back I was freezing cold and soaking wet but (name of organiser)she threw her arms around me and she knew what I was like about the Kayaking and she said I am so proud of you (Sally)

Sally's elation and personal satisfaction at the successful and pleasurable accomplishment of this activity is very evident within the latter part of the text. Her narrative reveals a profound change in her attitudes and values and demonstrates the beginnings of a positive growth in both her self-concept and self-belief.

Another example of self-growth comes from Simon's narrative when he relates how much courage he needed to speak about his volunteering activities to different groups of people. However he was determined to overcome these negative feelings, so he worked hard to manage his anxieties and develop his communication skills. His successes had a profound effect on his belief in his own abilities.

I like myself now I have a good opinion of myself not like before and all the stuff that has come after the Personal Best course – I was asked to go to the prison and talk how volunteering can change your life. I went and talked all about it – one of them was proper interested. But others said I'm not working for free – which I expected. When I went to the prison in…(name of prison) and I thought I am going to get things thrown at me, but they all listened really well and one of them came up to me and said you have inspired me to change my life and that felt amazing. Really amazing. I've never felt like that before, he said that to me, it increased my self-worth. It's almost as if all these people were waiting for me to get better to come and help them. But it took a lot of courage to go and speak in the prison. One of the first things we did on the PB course was to talk on anything in front of the class and before I did it I was really worried about it, I didn't sleep, I couldn't speak at first I was so worried about it. But in treatment they taught me to say yes and not be paralysed by fear and afterwards I thought no but because I said yes I did it and I felt amazing afterwards

and then I went to lots of different places to talk about it. I went to talk to young kids in a school I think they were year 8 and that was very scary – I talked to them about my experiences with drugs and I felt really stupid and afterwards I got lots of daft questions and then afterwards these 2 young girls came up to me and said you made us cry and we don't want to take drugs now. And that's all about volunteering, every time I do it I feel stronger, standing up and talking in front of people is a big thing for me. *(Simon)*

Simon was so keen to speak about the personal benefits of volunteering that he was willing to put himself in very challenging situations. He was concerned that people in the prison would throw things at him and in the school he talked about and answered questions relating to his hidden drug taking life, to people he did not know. Although these actions required much physical and emotional courage he was rewarded with a range of personal development benefits. He felt stronger, happier with himself, and of value to people.

The evidence presented within this 'wider personal resources' theme suggests that the participants gained a range of assets, including the development of individual social capital, which Green and Tones (2010) identify as providing positive benefits. Within the narratives it is evident that individual social capital acted as a buffer against stressful times on the course and during volunteering. It also supported the participants by preventing them reverting to their old health damaging behaviours and as a

consequence improved their quality of life outcomes. Although their social networks were initially small they continued to increase over time.

CONCLUSIONS

The themes discussed in this chapter relate to the self-resources and wider personal resources gained by participants following successful completion of the PBVTP. The narratives indicate transformational learning experiences and epiphanies related to their involvement with the PBVTP. Transformational learning prepared them to be more open to and seek out other prospects, which were diverse and extensive. For transformational learning to occur a number of criteria must be achieved (Mezirow 2004, p.27). During the PBVTP the students were actively involved within their own transformational learning process. They reflected on their own and other people's beliefs and values during teaching and learning sessions, in conversations, discussions and by observation. This learning inspired the development and acceptance of new attitudes, beliefs, values and different codes of behaviour. However the learning also encouraged them to constantly seek justification of these personal changes through discussion and reflection.

Although many of the participants were encouraged to take up volunteering opportunities prior to the PBVTP, few took up the challenge and no one enjoyed the activity. Listening to the narratives at that early stage it is probable that the participants lacked both self-confidence and self-belief and were anxious about mixing with the general public. However all the participants voluntarily agreed to attend the PBVTP, this may have been because of its Olympic status. During the course they practiced and developed a wide range of skills including communication and interpersonal skills and then undertook a number of volunteering activities involving the general public. From this stage onwards there is a marked change in the participants' attitudes to volunteering, they start to enjoy these occasions and seek out other volunteering events both formal and informal. It is probable

that their self-esteem and self-confidence developed over the duration of the course, which positively influenced their volunteering attitudes and behaviour.

Indeed what is visible is that through their narratives the participants demonstrate an increasing self-awareness, enhanced self-concept, raised self-esteem, improved self-efficacy and a general feeling of more control over their lives. Confidence in their skills of communication, decision making and team working are also commented upon. The narratives indicate operational evidence of transformational learning both during and following the PBVTP. The PBVTP is seen as a major event in all of the participants' lives.

Chapter 5

CONCLUSIONS, REFLECTIONS AND RECOMMENDATIONS

INTRODUCTION

This chapter aims to identify and discuss the key research findings from my study. It will also draw possible implications of the research with regard to future volunteer course development, health promotion practice, policy developers, volunteer co-ordinators and potential future research. Proposals for dissemination of the research will also be discussed. Although I have sited myself throughout this research I will also offer further reflections on aspects of the research process.

CONCLUSIONS

As a public health practitioner and lecturer I am interested in exploring the health benefits of volunteering for socially disadvantaged people. The association between health and socio-economic status is well recognised and documented (Whitehead 1987, Townsend and Davidson 1988, Acheson 1998, Marmot Review 2010). However despite numerous policy initiatives to address this issue there has been little improvement. It is now recognised that developing the personal and wider social resources which underpin autonomy and social participation are essential for health within all social groups (Marmot 2006). The literature review within this work discusses the evidence for volunteering as a way of acquiring the resources and skills necessary to underpin the development of personal autonomy and social participation. Current research studies suggest that these benefits may be acquired through volunteering; however it is not known if this holds true for

all groups of people. There has been limited research in the field of volunteering for people not in education, training or employment. This study sought to investigate the benefits of volunteering for a group of people not in education, training or employment. It paid particular interest to the personal acquisition of health and social resources. To meet the study criteria I reviewed a number of different volunteering schemes and eventually chose to investigate a volunteering scheme launched and funded by a multi-agency partnership. Partners include national, regional and local government, SkillsActive and the London Organising Committee of the Olympic and Paralympic Games (LOCOG). The Personal Best course provides a volunteer training programme specially designed for unemployed and socially excluded people within England. Its main aims are to raise ambitions, generate career and employment choices. The programme is delivered by 50 providers in England. This research concentrates on the course delivered at a FE college on the south coast. six participants were recruited to the research via the snowballing technique. All had successfully completed the PBVTP.

Prior to the PBVTP it is evident that the personal and social identity of the participants was defined by their past addiction problems or mental health illnesses which socially excluded them from mainstream society and further influenced the negative feelings they had internalised. The accumulation of these factors contributed to low self-esteem, feelings of low self-worth and a lack of belief in themselves and their abilities. For many their previous addiction problems or mental health illness meant they were unable to work or participate in their local community or within wider society. One participant spent most of her time in bed where she deliberately stopped seeing other people. For several of the participants their marriages and relationships had failed as a result of their addictions, for others the family support had been strongly tested, while some felt abandoned by their families. For most of the participants their only contacts, were those who shared their addictions or mental health problems. As a consequence the participants had limited social networks. For a long period of time their health had not been a high

priority, most of the participants had lived chaotic lives; abusing their physical bodies by sleeping rough, consuming large amounts of alcohol and or drugs, eating a poor diet and not caring for or maintaining bodily hygiene.

The participants came to the PBVTP via a number of routes, including referral from rehabilitation centres and welfare services. Many had opportunities to participate in volunteering schemes before but had turned them down and expressed a dislike for the activity. In this case it could be that the appeal of volunteering at the high profile London 2012 Olympics and Paralympics was the catalyst to register for the PBVTP course. Although this seems doubtful from their narratives, as only one of the participants wanted to be a volunteer in London at the Games while the others were content to volunteer for local events in their neighbourhood.

Through collecting the biographies of the six participants I was able to investigate the influences and benefits of the PBVTP from the participants'' perspectives. This research addresses two major objectives:

Objective 1

Explore the self-reported personal and social resources acquired by people who have completed the PBVTP paying particular interest to self-reported assessments of self-esteem.

Objective 2

Investigate the personal perceived health and wellbeing experiences of the participants.

Health and wellbeing

The experiences and benefits of volunteering for the participants are similar to those reported in other qualitative volunteering studies, although the participants in this study have experienced social exclusion, unlike other

studies, and there is some important variance in outcomes. The mainstream volunteering literature recognises a number of benefits including; increased physical and psychological wellbeing ((Musick and Wilson 2000), promotion of self-esteem and self-confidence (Harlow and Cantor 1996), improved quality of life (Wheeler *et al.* 1998), increased happiness levels(Meier and Stutzer (2006) and provision of a source of personal identity (Baines and Hardil 2008). As previously stated most of the literature on volunteering relates to people, who are well educated, well connected and well resourced. The data from this study suggests that the participants, who have few economic resources, also acquired these benefits, with probably the most significant and pervasive benefit being enhanced self-esteem.

The nature of the teaching and learning activities within the PBVTP encouraged involvement and team working, although the activities were challenging they provided the students with a strong sense of achievement when the tasks were accomplished. *To get confidence you have to do things you don't want to do (Simon.)* As the students were involved in much group work the participants' communication and interpersonal skills developed and improved. These abilities were learnt, practised and refined within the theoretical seminars and the practical volunteering placements. *You are building up your social skills and you start to feel you are worth it (Simon).* Over time the participants felt they became more assertive, more able to negotiate, make decisions and informed choices. As a consequence of these positive experiences the participants began to construct a new confident sense of self. *People saying thank you, it helps how you feel about yourself (Gareth). I like myself now (Simon).* Work by Greenhalgh (1994) maintains that self-esteem is a key aspect of self-concept and is influenced by how much people feel valued, how they view they are treated, their successes, achievements and feelings of personal control. Data from this research indicates that enhanced self-esteem and self-confidence were acknowledged by all participants. It *helped my confidence so much (Linda), my self-confidence and my self-belief just grew again (Stuart).* MacDonald (1994) emphasises the importance of high self-esteem for emotional, mental and

social health and Zimmerman (2000) for happiness, while Glick and Zigler (1992) acknowledge its important influence for wellbeing. The data from the participants' biographies identifies positive changes in self-esteem and self-concept and recognition that the activities within the PBVTP provided a starting point for both the initiation and development of these self-resources.

High self-esteem and positive self-concept are important factors within autonomy and social participation (Marmot 2006) and empowerment (Green and Tones 2010). Promoting these key attributes is also central to health promotion, which seeks to enable people to take control of their health (WHO 1986), create autonomy (Seedhouse 2002) and support the adoption of a positive salutogenic view of health and wellbeing (Antonovsky 1996) and the development of internal coping strategies (Naidoo and Wills 2009). This study indicates that the PBVTP provides opportunities for low resourced people to gain the attributes and self-resources necessary for the growth of personal autonomy, the development of individual choice and enables participants to be actively involved within their communities and therefore to share the generated societal benefits. Weare (2000) acknowledges the interconnectedness of these attributes and their contribution towards individual control and personal health outcomes, while Marmot (2006) maintains that social participation is a key influencing factor for both individual and community health. As a consequence of attending the PBVTP the participants state in their narratives that they gained a much wider group of friends and acquaintances which, according to Lin (2001) acts as a collection of resources for the individual to access as necessary. Several of the participants recognise the positive benefits of support, information and friendship offered by their extended network although Lin (2001) suggests that the quality and extent of the resources people can access will depend on their social and economic position, occupation and community, while Musick and Wilson (2008) acknowledge that people with more resources are more likely to make better use of their social resources. Nevertheless having a wider social network provides influential health benefits for the individual

(Wahl *et al*. 2010) and is clearly more advantageous than a more restricted network.

Giving something back

Many of the benefits identified by other volunteers are also evident within this study, for example improved physical and psychological wellbeing, enhanced social networks, improved work and career attributes and reduction in isolation (Wilson and Musick 2000; Low *et al*.2007). Within all of the narratives the participants talk about job satisfaction and having a pride in their volunteering work and wanting to actively participate in their communities *by giving something back* (Linda) or *my community has done so much for me, this is my chance to do things for my community* (Sally). Interestingly this idea of 'giving something back' is not high on the list of motivations for other mainstream volunteers (Low *et al*.2007). Although The Helping Out Survey (Low *et al*. 2007) indicates that volunteers from groups at risk of social exclusion are more optimistic about the acquired personal benefits of volunteering, than other groups with higher resources. The data within this study demonstrates that all participants recognised the support, help and assistance they have gained from the organisations within their local community. And all of the participants were keen to reciprocate that help through volunteering for and within the local community.

Bespoke Course

As previously identified there is little research on volunteering and low resourced individuals, in general volunteers are high resourced, well-educated individuals (Plagnol and Huppert 2010) who require little preparation for volunteering (Musick and Wilson 2008). Indeed Bowgett's study (2006) suggests that less resourced people may be deterred from volunteering because of negative attitudes from people who do not share or understand their circumstances. The findings from my study of people not economically active, in education or training indicates that preparation for

volunteering is essential for this group and providing a course which is organised around their needs is beneficial for both the individuals and community. Some of the participants had been exposed to volunteering prior to the PBVTP, many of them saw no benefit or value in the activity. *I saw other people…do volunteer work and I could not understand it (Simon).* They had no concerns or interest for others in their community. It may well be that these students did not have the skills or understanding to undertake volunteering activities prior to the course and therefore evaded involvement. For many of the students it was both demanding and difficult to talk to '*normal*' people in volunteering situations who did not share their similar backgrounds. They considered themselves as *'outsiders'* and found they had little in common with other people and were unable to strike up an easy conversation or engage in small talk. However as time progressed and as their inter personal skills improved and they became more confident they began to feel more comfortable talking and being in the company of '*normal* ' people during volunteering placements. Volunteering activities and the PBVTP also provided a framework for the day and made the students feel '*normal, like other people'*.

The data in this study suggests that the PBVTP provides a platform for the students to develop the necessary skills and knowledge so that when they embarked on volunteering activities in the community their efforts were successful. Work by Haski-Leventhal (2009) proposes that socially excluded people are less likely to volunteer because they do not have the skills or knowledge for or about volunteering and this further excludes them from the benefits of volunteering. *I just couldn't understand why people would come back ….to do this* (volunteering) (Simon). The PBVTP was available only for socially excluded people, which this group of people found advantageous as they quickly recognised that other group members had similar backgrounds and this facilitated acceptance and easy integration into the group.

PBVTP an epiphany

The participants' data reveals that the PBVTP appears to have provided a turning point or as Denzin (1989) terms it an epiphany in the participants' lives. The data does not demonstrate differences between gender and age. However it is not possible to identify exactly when this epiphany occurred for each participant, during or after the course, but by reading the participants' biographies as a whole document, it portrays the PBVTP as a major event within their lives, *its life changing (Sally)* which influenced every aspect of the lives (Denzin 1989). Some of the participants' descriptions of their experiences within the PBVTP see it as momentous, for others the impact was less dramatic but the effects were equally far reaching, which again indicates that the PBVTP was an epiphany for them (Erben1998). The data demonstrates that as a consequence to this major event all the participants underwent some level of transformational learning, which totally altered their world view (O'Sullivan 1999). Mezirow (1997) maintains that transformational learning comes about when people reflect on their own beliefs and values, a process which was encouraged and facilitated within the PBVTP, and then as a consequence deliberately adopt a new world view.

This research provides a snapshot review of the participants lives post their experiences of the PBVTP and is not able to confirm if the acquired learning and changes will endure over time or will prevail in times of personal difficulty. As previously stated all of the participants had completed the PBVTP some six to twelve months prior to these interviews taking place.

As previously discussed it would be helpful to identify at what stage in the PBVTP transformation learning took place. However the generated data does not disclose this information specifically and this may therefore be a limitation of this study design. Total control of the interview was passed to the participant, allowing them to offer their narrated biographies in relation to the PBVTP, in a style which suited them. It was not until I reached a much later stage of the thematic analysis that the value of gaining an understanding of the time frame of transformational learning for each

participant was seen to be relevant. However the data does reveal that participant transformational learning took place because of PBVTP attendance.

Study Limitations

This study recognises that the participants who volunteered for this study are likely to do be different from other students who completed the PBVTP and therefore caution should be applied to simple generalisations. No research has been undertaken on the students who completed the PBVTP but did not want to be involved in the research, or on the reasons why many students signed up for the course but failed to attend. The major advantage of this study is the depth and richness of the generated qualitative data for this under researched group through the use of biography, which ensures the circumstances and experiences of the respondents were all valued and their experiences and life events are grounded in both their cultural and social context (Goodson 1997).

Hawthorne Effect

It is necessary at this stage of the research to offer some explanation of the research findings. It is possible that something similar to the Hawthorne effect was evident within the participant biographies. The Hawthorne Effect refers to experiments carried out in the 1920s and 1930s when people seem to work harder when they were participants within experiments, despite the differing variables. Their research findings suggest that people may change their behaviour when they are receiving attention from researchers. My own study acknowledges that several of the participants expressed their pleasure at being offered the opportunity to talk about themselves, the course and their lives generally. They found the process both therapeutic and constructive and as a consequence it may be that they said things which they thought I the researcher, would want to hear, or they over emphasized some of the course benefits. There are six participants within this study and it

is therefore not possible for this research to prove or disprove this factor. This work accepts that the participants have offered truthful accounts within their biographical narratives but acknowledges that accounts change and are modified over time. To gain a more rounded and holistic view of the course outcomes it may have been helpful to interview other people involved with the course. For example course leaders and those involved with organising and monitoring volunteer placements. Indeed this may be an aspect of future research work which may add further insight, understanding and help towards the development and design of future volunteering programmes.

RECOMMENDATIONS

There are a number of recommendations which come from this research. The work is a biographical study and although it recognises that sometimes it is possible for a small group of people to speak for much larger groups it also acknowledges that the personal circumstances of the participants and the individual nature of the PBVTP are unique. And as is the case with much qualitative research the results are not widely generalisable. However there are some broader points which are worthy of consideration:

i *For Policy Developers* – Many of the participants within this study were recipients of volunteer services in the past. However by undertaking the PBVTP, which prepared them for volunteering activities, they gained a wealth of benefits and acquired the skills necessary for volunteering and actively delivering the volunteering service. Therefore this study recommends that socially excluded people are prepared for and involved in the delivery of volunteering services and are not merely beneficiaries of said services.

ii The PBVTP has equipped socially excluded people with an extensive range of skills and knowledge which have raised their expectations and enabled several participants to gain access to further and higher

education and entry into the world of work. This is a very constructive outcome of the PBVTP and as a consequence this study recommends that volunteer preparation courses for socially excluded people should continue to be funded and provided.

iii *For Course Developers and Volunteer Co-ordinators* - Socially excluded people are often excluded from volunteering because of a lack of volunteering skills and poor knowledge of volunteering opportunities. These restrictions further exclude them. Therefore socially excluded people may benefit from attending a bespoke volunteer preparation course prior to undertaking any volunteer activity. Volunteer training needs to be targeted specifically at this group and courses should be designed and developed to meet their requirements.

iv *Suggestions for Health Promotion Professionals* - The PBVTP provides multiple benefits for socially excluded people, including positive outcomes for improved self-concept and self-esteem, improved health and wellbeing outcomes, increased personal autonomy, and active social participation. This work recognises that the PBVTP has the potential to be an effective public health tool capable of enhancing personal self-belief, improving self-esteem and facilitating social participation, which are all key attributes for improving health and wellbeing. As a consequence this research will be disseminated widely to practitioners working within the fields of health, social care and education through a variety of mediums including academic, practitioner journals, conferences, presentations and teaching opportunities. The aim would be to equip practitioners with the knowledge and understanding of the benefits of volunteering so that they can work collaboratively with organisations which provide volunteer training and placements and also to support and introduce socially excluded people to volunteering courses and volunteering placements.

v This work recommends that practitioners should explore the opportunity for setting up volunteer activities within their communities and include and support socially excluded people to work jointly and actively within such services.

vi *Dissemination Through Teaching Opportunities* – As a lecturer working within a university setting, involved in teaching both student and qualified health care practitioners; I will incorporate the findings of this research into relevant teaching opportunities.

vii *Dissemination to Volunteer Organisations* – This work will be made available to organisations which champion volunteering at a national and local level. The findings will be disseminated to Volunteering England, local volunteering organisations and local authority services which provide services for social excluded people and often co-ordinate volunteering schemes.

viii *Suggestions for Further Research* – This research recognises that the PBVTP provides an extensive range of benefits both to individuals and the wider community. This work recommends that further research is carried out into the value, contribution and role of PBVTP graduates in sustaining and supporting communities and community projects.

REFLECTIONS

Throughout this research I have situated myself within the work and acknowledge my role and any predisposition I may have as a white, female, middle class, public health lecturer. I am also aware that the findings of this work are based on my interpretations of the data and therefore a degree of bias will be evident, although I have tried at all stages to remain as impartial as possible.

As a reflective practitioner in the field (Argyris and Schon, 1974) I found that it was a natural extension to reflect on all aspects and areas of this research. I kept a research diary and recorded reflections using Blaxter *et al*.'s (2001) four categories, which include observational, methodological, theoretical and analytic areas. Within the diary I attempted to capture a wide range of experiences and thoughts during all stages of the research. The diary documents my interest in the use of autobiography and biography as a research methodology. I was initially exposed to the methodology during the second year of the taught component of the Doctorate in Education and was quickly able to identify many similarities between biography and the life time stories I routinely gathered from clients in order to understand their current situations and offer tailored client centred care. Further reading and research into biography determined it as my preferred methodology for this research. However searching for an appropriate research topic proved both elusive and problematic. Although I was interested in undertaking a research study which addressed public health issues my thoughts fluctuated between various topic areas. Through my interest in self-esteem and its importance for health outcomes I was drawn to consider projects which addressed the enhancement of this important aspect of human life. In both my personal professional life I am involved in volunteering projects and recognise the benefits they offer to both the volunteer and the wider community. As a consequence I resolved to find schemes which offered volunteering to socially excluded people, as it appeared to me that they had the most to gain. Also there appeared to be little research into volunteering by this group

of people and little opportunities for this group to become actively involved in volunteering. The research diary records much frustration at my inability to source a project of interest and later the painstaking work involved at seeking out a volunteering project to meet my criteria.

After considerable searching I located the PBVTP and following much negotiation I managed to access the course at a local FE college, where the staff involved in the PBVTP were very interested in the proposed research. I was delighted to discover the PBVTP and proud to have met the successful students who kindly agreed to take part in this work. In the diary I also recorded information relating to the contextual nature of the participants' accounts as the interview locations differed. All interviews were held in various private rooms with access to refreshment making facilities. In addition I tried to capture some of the constraints and the principal features which impacted on the structure and content of the participants' accounts and endeavoured to identify the features which helped the students assemble their narratives.

The diary also acknowledges my own biography as I recorded events which were happening in parallel to me. My own personal life was in some turmoil at the time and I tried to understand the effect of these events and how they may have further influenced the production of knowledge within this research. I acknowledge that a major reason for selecting the 'single question interview technique' (Wengraf 2001) was to ensure that I adopted a minimalist-passive approach within the interview process (Jones *et al*. 2011). Thereby ensuring the participant had total control of the whole narrative process. Other reflections record my inability at times to give sufficient thinking and writing time to the doctorate because of the more pressing teaching and assessment requirements of my job. However determination and resolve have eventually won through as I finally move towards completing this thesis. When I look back at the entire process of selecting the research, carrying it out, interpreting the data and then finally structuring and writing up, I am aware of how much I have learnt through this whole process

and how undertaking and completing this work has been an epiphany within my own autobiography.

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APPENDICES

Appendix 1

UNIVERSITY OF Southampton
School of Education

Participant Information Sheet

Personal Best Stories – a Biographical Approach

Researcher: Anne Mills

Ethics number:

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

I am a lecturer at Bournemouth University with an interest in public health and volunteering. I am keen to explore the influence of volunteer training on people and will be asking for your opinion on the course and its impact on you. This research is supervised by Dr John Schulz, from Southampton University.

Why have I been chosen?

I have contacted you because you have completed a Personal Best Volunteer training course.

What will happen to me if I take part?

If you agree to take part in this research I would like to interview you, to find out what you think the outcomes of the Personal Best Training are for you. The interview would be held at the college, at a time convenient to you and take on average between 1 to 3 hours. It may be necessary to request a second interview with you.

Are there any benefits in my taking part?

Although there are no personal benefits to you for taking part in this research, there may be wider benefits, because this research may contribute to a greater understanding and knowledge base on volunteer training programmes.

Are there any risks involved?

There are no risks to you for taking part in this research, all information will be confidential. In the research data a pseudonym will be used, rather than your own name. Your name and details will not be recorded in the research. Your interview will be taped and when the tape is transcribed you will be offered the opportunity to read the transcript and change any inaccuracies or details you are not happy with

Will my participation be confidential?

All research data collected will comply with the Data protection Act. All information will be confidential; data will be coded and stored on a password protected university intranet.

What happens if I change my mind?

You have the right to change your mind and withdraw from this study at any stage.

What happens if something goes wrong?

You should contact the Chair Ethics committee, School of Education, University of Southampton, Highfield , SO17 1BJ

Where can I get more information?

Should you require further information please contact Anne Mills on amills@bournemouth.ac.uk 01020968389 or 07946722004 or if you prefer another member of the research team Dr John Schulz 02380 597458

Appendix 2

UNIVERSITY OF Southampton
School of Education

CONSENT FORM

Study title: Personal Best Stories a Biographical Approach

Name of Researcher: Anne Mills

Please initial the box to indicate that you have read and understood the statement

1. I confirm that I have read and understand the participant information sheet for the above study ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without my legal rights being affected. ☐

3. I agree to take part in the above study. ☐

Participant	Date	Signature
Anne Mills		
Researcher	Date	Signature

Data Protection Act

I understand that data collected about me during my participation in this study will be stored on computer, and that any files containing information about me will be made anonymous.

I agree to the University of Southampton recording and processing this information about me. I understand that this information will be used only for the purpose of this study and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act.

Signature …… Date ……

Appendix 3

UNIVERSITY OF Southampton

Ms Anne Mills
School of Education
University of Southampton
University Road
Highfield
Southampton
SO17 1BJ

RGO Ref: 7893

28 February 2011

Dear Ms Mills

Project Title Personal Best Stories - A Biographical Approach

This is to confirm the University of Southampton is prepared to act as Research Sponsor for this study, and the work detailed in the protocol/study outline will be covered by the University of Southampton insurance programme.

As the sponsor's representative for the University this office is tasked with:

1. Ensuring the researcher has obtained the necessary approvals for the study
2. Monitoring the conduct of the study
3. Registering and resolving any complaints arising from the study

As the researcher you are responsible for the conduct of the study and you are expected to:

1. Ensure the study is conducted as described in the protocol/study outline approved by this office
2. Advise this office of any change to the protocol, methodology, study documents, research team, participant numbers or start/end date of the study
3. Report to this office as soon as possible any concern, complaint or adverse event arising from the study

Failure to do any of the above may invalidate the insurance agreement and/or affect sponsorship of your study i.e. suspension or even withdrawal.

On receipt of this letter you may commence your research but please be aware other approvals may be required by the host organisation if your research takes place outside the University. It is your responsibility to check with the host organisation and obtain the appropriate approvals before recruitment is underway in that location.

May I take this opportunity to wish you every success for your research.

Yours sincerely

Dr Martina Prude
Head of Research Governance

Tel: 023 8059 5058
email: rgoinfo@soton.ac.uk

Appendix 4 a&b

Appendix 4a

Example of Coding from a Participant Narrative.

But so many nice things have happened since I did the

course and I feel that something good is gonna happen

we have been offered other things courses and stuff.

I have just taken everything that they say apart from

the computer course which I have a bit of a medical problem

with. I don't like letting people down and if there is

targets to reach I will reach them if I have to stay up for 24/7.

All night I am a bit of a bugger for that. I leave things until

the last minute and then I'm up for 48 hours trying to

build it (laughing) but I get it done. Touch wood I haven't

let anyone down. But I have been thinking over the last

couple of days of doing the sponsored build.

But whether I would be able to...I could see it in my head, if I can

see the picture in my head I can build it. I was gonna speak to

NAME OF ORGANISER as that could raise some money for here

and that would be challenging. It would be a 24 hour build. I

Comment [AMM1]: positive

Comment [AMM2]: optimistic

Comment [AMM3]: new opportunities

Comment [AMM4]: new opportunities

Comment [AMM5]: personal pride /supportive of others

Comment [AMM6]: cost to self

Comment [AMM7]: supportive

Comment [AMM8]: creative

Comment [AMM9]: giving back

Comment [AMM10]: hard work

want to build a house with some furniture out of 2 litre bottles

of coke and garden canes. So I am wondering if I can do it in

24 hours. That is something for me to think about (laughs).

Comment [AMM11]: creative

Comment [AMM12]: purpose

Appendix 4b

Example of Coding from a Participant Narrative.

we did one where we raised money for the volunteer centre and we went to (names location) house in the grounds and people were doing walks all round the grounds and they had to pay to get in and my daughter came with me and we sold coffee and tea and biscuits and cakes and we made £130.12. My daughter was working with me and we had another new girl started but because I'd been doing it for so long I completely took over I just said to the girls right you can do this, and they said can you do the teas because of the water they didn't want to use the hot water tank and this is all the things I've gained from Personal Best through volunteering because it's just given me the confidence. I met family, did the tea and coffee but I couldn't have done that a few years ago. A few years ago I couldn't even get out of bed. The depression, the drugs and the alcohol a few years ago I couldn't even get out of my flat let alone serve people coffees and tea's and things like that, you know I really was in a

Comment [AMM1]: Giving back

Comment [AMM2]: success

Comment [AMM3]: confidence

Comment [AMM4]: self-skills

Comment [AMM5]: attribute of the PBVTP

bad way. You know I'd been taking amphetamines 4 or 5 times daily for 5 years, I'd been drinking daily for 5 years and I was a mess. I was sectioned, I lost the plot a little bit. I had no confidence, I hated myself I wanted to die, I was really wanting to die. I'd had a horrible, horrible time of it and I didn't think I'd ever, ever get out of it. I'd put my children through it, I nearly lost my children they were very close to being taken away from me by Social Services, It was just the worst time of my life basically. And at the time you just can't see any way out of it I was so depressed I just couldn't get out of bed or anything and I just couldn't see any way out of it I thought It will be just like this forever, I could just see me depressed and there is like a light at the end. For me I was just ... the drugs and the alcohol from a young age. The drugs for me didn't come in to it until I was a little bit older in my teens and so you know, I'd had a child then as well so it just wasn't good but now I'm just, well my mum says to me I've got my daughter back my mother says, because at one point my sister had a blocked phone from me because I was so abusive and I did stuff I'm not proud of but I'm here, I'm alive

Comment [AMM6]: unhappy - isolated

Comment [AMM7]: deeply unhappy – low self-value

Comment [AMM8]: low self value

Comment [AMM9]: consequences of addiction

Comment [AMM10]: trying to find a solution

Comment [AMM11]: changed

Comment [AMM12]: self-dislike – low self value

and I'm doing well basically, and thanks to names volunteer co-ordinator and Personal Best basically. I just found the relationship of being in a group, I just found I didn't like it very much but the Personal Best I used to get a lift up there in the mornings. I used to go in there and get hot chocolate from the Cafeteria in there and we'd start about 9am when everyone turned up and you know when people who'd been there for a day and they didn't turn up, and I mean when people and there was a couple of people who had been there a while and decided to come and go when they felt like it and I started to feel annoyed because I thought we are doing this, we don't have to pay for this, it's life changing plus it's something for the community and I used to get quite annoyed but that's my issue but I used to get like where are you because we'd learnt to work as a team, basically we learnt to work together. It wasn't just singled out, we were all together and we helped each other out together, we did our work together and I made a CV which I've actually handed out to about 5 different people at the moment for jobs so I wouldn't actually have known where to start, but we did

Comment [AMM13]: attributes success to volunteering course

Comment [AMM14]: group work difficult

Comment [AMM15]: structure

Comment [AMM16]: valued

Comment [AMM17]: epiphany

Comment [AMM18]: giving back

Comment [AMM19]: team

Comment [AMM20]: group support

Comment [AMM21]: group support

Comment [AMM22]: work opportunities

CV's on the computer. When we first did it, the first couple of days I must admit it was a bit full on, it was a bit they'd ask me questions and I was a bit scared but she said she did that for a reason, she did it that was for the first two days, she said none of us had worked for a very long time and she wanted to get our memories jogging, so for the first two days it was bang, bang, bang, question after question and I said to myself, I'm not going to get on with that and then after a few days it sort of slowed down a bit but she explained there was a reason why she did that and it was good in the end but it was a bit like, ohh let me answer that question first, but it worked at the end of the day because it did get us all motivated and you know it got us all going and we walked round the pavilion and we had a choice and our group did a treasure trail for children, not actually did but a scenario and we had to make directions and a little map of all the places the children would go and what stops and landmarks they would stop at and we all had a little role in that, but we all got given a role, but funny enough at the end of it we all got given our roles which we all put together and just mucked in

Comment [AMM23]: course challenging

Comment [AMM24]: course anxiety

Comment [AMM25]: out of the workplace

Comment [AMM26]: course challenging

Comment [AMM27]: initial anxiety

Comment [AMM28]: collective experience

Comment [AMM29]: course encouragement

Comment [AMM30]: group task

Comment [AMM31]: collective

Comment [AMM32]: team work

together if you see what I mean it just worked out better that way. But we did have fun, we really did have fun.

Comment [AMM33]: team work

Comment [AMM34]: fun