

# Participatory action research to enhance the collective involvement of residents in elderly care: About power, dialogue and understanding

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[journals.sagepub.com/home/arj](https://journals.sagepub.com/home/arj)**Susan Woelders and Tineke Abma**

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**Abstract**

The collective involvement of patients and clients in health care organizations is valued in our Western society. In practice, giving form to this involvement seems to be a complex process. In this paper we present our learning experiences with a process of enhancing the involvement of older people in a residential care home in the Netherlands, by using a participatory action research approach, called PARTNER. This approach is inspired by responsive evaluation and developed for the context of long-term care. We use concepts of Habermas' theory to understand what happens when trying to create communicative spaces through dialogue. Our learning history shows that the involvement of residents is not an easy task, because power issues are at stake. System values seem to dominate the lifeworld and expert knowledge seems to be more valued than expressed emotions and narratives of residents. Researchers who use participatory action research must be aware of these issues of power, often hidden in language and discourse. Dialogue can be a vehicle to enhance mutual understanding, when attention is paid to underlying values, assumptions and meanings of all people. Then, the gap between system and lifeworld can be bridged and communicative spaces can be opened up.

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**Introduction**

The collective involvement of patients and clients in decision-making and policy is considered of value in health care organizations in our Western society. Involvement can be seen as a democratic or ethical requirement, related to notions of empowerment and the right to be involved in decisions concerning one's care and treatment as well as health care policy (Beresford & Branfield, 2006; Cornwall & Shankland, 2008; Crawford et al., 2002). Also, involvement can contribute to an improvement in quality of care (Barnes, 2005; Bate & Robert, 2006; Crawford et al., 2002; Schipper, 2011). In several countries like Australia, Belgium, Ireland and the Netherlands, legal frameworks support the involvement of clients in the decision-making processes and policy making within health care organizations (Baur, 2012; O'Dwyer & Timonen, 2010; Petriwskyj, Gibson, & Webby, 2014; Van Malderen, De Vriendt, Mets, & Gorus, 2016). In the Netherlands, for example health care organizations have the legal obligation (Wet Medezeggenschap Cliënten Zorgsector) to establish a client council, based on the idea that the daily experiences should reach the board of the health care institution and that decisions of the board should match this input from clients (Van der Voet, 2005).

Despite the assigned value of involvement and the support of legal arrangements, collective involvement is in practice a complicated and complex process (Abbott, Fisk, & Forward, 2000; Baur, 2012; Petriwskyj, Gibson, & Webby, 2015; Van der Meide, Olthuis, & Leget, 2015, Van Malderen et al., 2016; Woelders, Abma, Visser, & Schipper, 2015). Health care organizations often choose a managerial or a consumer approach to give shape to involvement, but this has its shortcomings (Abma & Baur, 2014a). These approaches leave little room for the voices of clients themselves and approach them as independent, autonomous persons. In practice, clients need help to articulate their voices (Baur, 2012; O'Dwyer and Timonen, 2010; Petriwskyj et al., 2014). Besides this issue, formal ways of involving clients in client councils are based on institutional democratic representation and council members are often led by the more active and vital clients or family members, and may not adequately represent the values and interests of all clients, including those who are not assertive and in vulnerable situations. Moreover, client councils are frequently reactive and responding to strategic policy issues, and do not have enough room to actively set the agenda. As a result, members often feel they do not have enough influence. Underlying asymmetric relationships and power issues in relation to professionals and management are often at play (Baur, 2012; O'Dwyer & Timonen, 2010; Petriwskyj et al., 2014).

This makes a health care organization a complex context to work towards including voices of clients and patients.

## Background

The shortcomings of organizing formal ways of involvement via client councils were also experienced by management of health care organizations, leading to the wish for alternative forms of involvement. In this context we started a research project in a residential care home in the South of the Netherlands. First, we wanted to explore the involvement of clients in the formal resident council, from the perspectives of all people (management, care professionals and residents) (Baur, Abma, & Widdershoven, 2010). This study showed that the client council felt that they had hardly any influence on policy processes and managers felt that client councils were more of a hindrance than an equal sparring partner. These frustrations revealed a context of asymmetric relationships and differing outlooks among parties. While managers were oriented towards information exchange, council members expected more horizontal deliberation. An additional tension was that managers focused on long-term strategic issues for future clients (mergers, out-sourcings, etc.), whereas client council members concentrated on the daily life issues of current residents (activities, meals, gardens). In short, seen through a lens of the theory of Habermas, the system world dominated the lifeworld in the context of this formal client council (Baur & Abma, 2011).

These experienced shortcomings of formal involvement via client councils in the practice of the residential care home set in motion the search for alternatives. We explicitly wanted to engage with all those involved (residents and professionals) to take into account their perspectives and involve them in the research process instead of doing research on them (ICPHR, 2013; Kemmis, 2008; Reason & Bradbury, 2008). Therefore, we started a participatory action research (PAR) in another residential care home, with and for older people living in the residential care home in order to learn how to involve them in a more direct, participatory manner and to strive for change in daily practice (Abma & Baur, 2014b; Baur, 2012). Our PAR approach has been inspired by the tradition of responsive evaluation (Abma, Leyerzapf, & Landeweer, 2016; Abma, Nierse, & Widdershoven, 2009; Guba & Lincoln, 1989; Maurer & Githens, 2010; Stake, 2004). The aim of responsive evaluation is to create mutual understanding between people through dialogue. It is based on the idea that in dialogue the perspectives of people can merge and lead to new insights and understandings (Gadamer, 1960; Widdershoven & Abma, 2007). This is strongly linked to Habermas' concept of communicative action and the creation of communicative spaces as important notion in action research (Abma et al., 2016; Habermas, 1987; Wicks & Reason, 2009). In our PAR approach we therefore are committed to the value of participation of all those concerned around an issue or situation and striving for social change in which all human beings can flourish (ICPHR, 2013; Kemmis, 2008;

Reason & Bradbury, 2008). We do this by action (dialogue) as a way to learn and generate new knowledge.

The aim of our initial PAR in a residential care home in the South of the Netherlands was to search for alternatives to formal ways of involvement like the client council (Baur, 2012; Baur & Abma, 2014a). As mentioned before, the involvement of all people was an important goal but we explicitly wanted to start in the lifeworld of residents themselves as an alternative for the more system world led client council. This commitment was also given in by concerns over the marginalized position of older people in our society more in general and notions that residents need help to articulate their voices (Abma, 2018; Barnes, 2005). Besides that, health care organizations are often hierarchically organized, in which the expert knowledge of professionals is often highly valued and dominates the lay knowledge of clients and patients (Abma, 2018; Barnes, 2012).

In our PAR we started to work with a group of residents who talked about their experiences and concerns with living in the residential care home and about their wishes for practice improvements and change. This group was led by a facilitator (the researcher). The group chose one concrete theme to work on (in this case the meals that were provided). They thought about practical improvements around their issues and concerns (step 1). As a following step, the stories of the residents and their suggestions for improvement were brought into a separate deliberation in a group of professionals, who were involved with the chosen theme (in this case the meals, so care workers, volunteers and restaurant staff were involved). The professionals could formulate their perspectives regarding these issues themselves, in their own group (step 2). Then residents and professionals came together and talked about their issues and solutions, in order to come to practical solutions together through dialogue (step 3 and 4) (Abma & Baur, 2014b). Finally, residents and professionals came to agreement about collaborative action to come to these practical improvements (step 5). To stress the importance of partnership relations of all involved, this specific form of PAR is called the PARTNER approach by us (Abma & Baur, 2014b; Baur, Abma, Boelsma, & Woelders, 2013).

The experiences with this PAR approach in the residential care home stimulated us to experiment with the PARTNER approach in seven other nursing and residential homes and three other health care organizations (an organization for people with physical disabilities, a rehabilitation centre and an organization for mental care) between 2011 and 2016. The PARTNER approach can be seen as a concrete form of PAR, inspired by responsive evaluation, for the context of long-term care. We wanted to find out how our approach worked out in diverse contexts, with people from these organizations as facilitators of the participatory action learning process, without us as researchers being the motor of change ourselves. We did not want to fall into the trap of resident involvement being an ad hoc activity, based on project money and disappearing or resulting in business-as-usual when the researchers leave. In other words, we wanted to create a more sustainable start-off for change by assisting people in residential care institutions to become the motor of change themselves and to develop capacities to sustain

changes that had been made. Our role changed from leading the action research projects to the role of supporting people with the PARTNER approach.

In this article we will focus on one of the residential care homes in which we introduced the PARTNER approach in order to enhance the involvement of residents. We chose one case to present an in-depth understanding of the dynamics of the participation process (Abma & Stake, 2014). Inspired by responsive evaluation, we wanted to include the perspectives of all people, especially of those whose voices are not easily heard (the residents). Furthermore, we wanted to create a communicative space, in which dialogue could lead towards mutual understanding and the possibility that different perspectives could lead to new knowledge and insights in order to bring change (practical improvements). The aim of this article is to shed light on this process of involving residents in a health care organization by dialogue amongst all those involved. What can we learn about this learning process in relation to the praxis of action research? And what lessons can we derive from it about the participation of all those involved? We will use concepts of Habermas' theory in order to understand what can happen during PAR initiatives and learn lessons about PAR and our own role as researchers in the context of health care organizations. By doing so, we shed light on the dynamics and the role of power, dialogue and striving for mutual understanding.

### **Our PAR approach in a residential care facility**

In our PAR approach to study what happened in a residential care facility called River View, we followed an emergent design based on the issues of people involved. To gain an in-depth understanding of the context, the people and the process, we used participant observations during all meetings, informal talks and 10 semi-structured interviews, focusing on motivations, expectations, relationships and communication; difficulties and tensions in the process; and the practical changes achieved.

As described in the 'Introduction' section, people of the organization were the facilitators of the participatory action learning process. Besides studying the learning process, the researcher involved (first author) also supported the facilitators of the project. In addition to informing them about the content and the different steps and stages in the PARTNER approach, the researcher facilitated the facilitators and was a Socratic guide behind the scenes, in order to create mutual understanding and create opportunities for dialogue among people during the research process to enhance their understanding. Regular moments for reflections with facilitators and other people involved were part of the process. We are aware of the fact that our role differed from the traditional participatory action researcher who is directly working with all people involved in the process. We were a bit more distanced, and this outsider role enabled us to stimulate reflexivity among all involved.

During the whole research process, the researcher kept a log to describe the process and methodological notions in detail. The log was also used as a reflection

tool about the process and the role of the researcher herself (first person reflection) and was the starting point for reflection in the research team consisting of four academic scholars (second person reflection). As already mentioned, our role differed from the role of a more traditional researcher who is working more in the concrete practice herself. This had also consequences for the reflection process. We tried to stimulate reflection with and between the participants in River View and reflected with the facilitators on a regular basis. But our own reflection process was more at distance and took place in our own research team (instead of reflection with all participants of the PAR where the researcher is one of all the participants).

### **Setting**

River View was a residential care home for older people, situated in a lively neighbourhood of a city in the Netherlands. It provided care to 100 residents who all lived in their own apartments. Residents were not able to live independently anymore (due to somatic and/or cognitive impairments) and lived in River View permanently. They received support from the staff for personal and medical care, cleaning of the apartments and serving their meals. Care was available 24 hours a day. The average age of the residents was 81 years.

The management of River View was faced with problems of client involvement in policy making. Until recently, clients were involved in the policy making process by taking part in a client council. Due to a conflict between the members and management, the council was disbanded. Without a resident council, River View did not meet the legal requirements, resulting in negative financial consequences for the organization. The manager, a woman in her 50s with a professional background in care, was searching for ways to invite residents to be involved in the resident council again, but the atmosphere among residents had become very negative because of the conflict. The former client council members felt they had no influence and some of them were frustrated because they felt they were not taken seriously. The manager was also dissatisfied with the way things worked out in the resident council. She felt it was more a committee of complaints and she experienced that the residents were very negative. She felt it was very difficult to mobilize them and to work out things together in a constructive way. These problems matched the findings in the literature (Baur et al., 2010). At the same time, the manager felt an urge to solve the problem of lacking a client council because of the negative financial consequences. When she heard about our new project, the manager was very motivated to join our action research project to stimulate client involvement and collaboration between residents and professionals, hoping to stimulate the residents to join and become involved.

While the start of the project was partly instrumentally driven (the thread of financial cutback) and the decision to take part in the project was a top-down decision of the manager, in the start-up phase a group of 10 residents wanted to join the project, despite the negative experiences of the past.

### *Getting started*

At the start of the project, the facilitators were chosen by the manager. An important notion was that they would not have a hierarchical position in relation to the residents and that they were able to facilitate a group process. Therefore, the manager approached the spiritual counsellor of River View and asked him to become a facilitator. He, a man in his 50s, came up with the idea of working together with the student spiritual counsellor (also male, 25 years old), who was doing his traineeship at River View. From that moment on, they were the two facilitators. The spiritual counsellors themselves were motivated to work on this project because they shared the values of involvement and of residents having a say. At the same time, they also had their concerns. Because of conflicts in the past between the resident council and the manager, they had the feeling that there was a negative atmosphere about resident involvement in River View. 'It's a real hornet's nest', one of the facilitators mentioned at the start of the project. He felt under pressure to make the project a success. He also mentioned his concern about his professional position. As a spiritual counsellor, he was used to having a neutral stance, and he wanted to keep it that way. He was afraid of being caught in the political context of conflict.

Despite these concerns, and because of their ideal of giving residents a voice, the facilitators started enthusiastically and thought about a plan. One of the first steps was to recruit residents for the group meetings. They did so by using attractive flyers (Wanted: Residents with a View!), by presenting the project in group meetings for all residents and by approaching residents during informal, personal contact. The result of the recruitment was an enthusiastic group of 10 residents. The group, two men and eight women, came together in several meetings to talk about their experiences of living in River View. They ranged in age between 67 and 95 years old. Some of them had physical problems: some of the residents used walking aids; some of them used a wheelchair. The residents also had to face hearing problems. One of the women was blind. Some of the residents also had mental health problems, like loss of memory. Despite their disabilities, all of them were able to join the conversation. With some help from the professionals or facilitators, they came to a room to meet each other while drinking a cup of coffee or tea.

### *Sharing concerns in a group of residents*

During the group meetings, the residents expressed their concerns about the way they were informed about matters in the house. Examples of these matters ranged from activities for residents to management decisions about care processes and other decisions that affect residents. The residents felt they were not informed about changes that occurred and about the reasons behind these changes. This can be illustrated by taking a closer look at one of the meetings.

The group starts talking about the menu. They express that they prefer normal meals, not special ones. It's better to have two options and enjoy a nice meal than to have lots of options that nobody fancies, is the opinion.

Then suddenly one of the women suggests: "We don't have to talk about this. One of the residents told me that everything is going to change around the kitchen and the meals."

The facilitator asks the group: "Does anybody know about this in detail?"

None of the residents knew about these developments. They talk about "the boss", referring to the manager of River View. One of them says: "Again, this is something we are not informed about, we don't know."

The residents stated that not being informed and not knowing what was going on led to unrest and rumours. They also mentioned that they saw many practitioners, and they did not always know who they were. The residents expressed that they wanted to know the names of the practitioners and they came up with the idea of the professionals wearing nametags. They experienced that when they asked the staff about matters that were not clear to them, the practitioners often responded that they were not informed either. The residents felt that they were not taken seriously. One of them articulated:

Staff should not play dumb when you ask them something. That leads to the feeling you cannot rely on them. You keep asking yourself: do they know or do they not know? If staff are well informed, they can inform the residents too.

The residents' view on information was that it should not be one-directional. They not only wanted to receive information, but they also wanted to give information to the management. They wanted to be heard; they wanted their opinion to count. One of them said: 'I live here'. Another resident expressed: 'Sometimes I feel I have nothing to say here in the house, you then feel so small'.

This feeling and position of inferiority also came to the fore when the residents talked about the management. As we observed, they used words like 'the boss'; the manager was even called 'the queen' and 'Her Majesty'. They expressed their experience that the manager was at a distance and did not mingle with the residents. It is obvious that in this group they felt safe to express these feelings, despite the presence of the two spiritual counsellors as facilitators.

The residents did not only refer to information about organizational matters, but they also wanted to be informed about the situation of other residents. They wanted to know about other residents, to experience more personal involvement with each other, more engagement and connection. They referred to the fact that they formed a social community and that they wanted to keep in touch with each other. Therefore, they wanted to know what happened in the life of community members. As one of the residents expressed:

We are not informed when one of the residents of the house has died. Sometimes we only hear about this after several weeks. But this is part of the community, it is part of life. When you know, you can show a little compassion.



The residents clearly came up with a number of topics that concerned them. It became clear that they felt that they were not involved at all.

### *Residents thinking about solutions*

During the following group meetings, the facilitators stimulated the residents to think about possible solutions to their experienced lack of information and not 'being informed'. The facilitator used the term 'communication'. Let us have a look at the meeting. The facilitator said:

What can we do? What has to be done? It is important that you as a group make clear what you think about the way things work out. It's important to show the professionals your experiential perspective. How can we improve communication?

One suggestion brought to the fore by the residents was including information at the end of the weekly programme that residents received in their mailboxes.

One of the residents continued: "The information board in the elevator is hung too high. Not everybody can look at it—for example, those who are in a wheelchair." Another woman responded to this by suggesting that an information board could be placed in the general rooms of River View where everybody can see it. The conversation degenerated into chaos, because everybody was talking at once. Everybody wanted to have a say.

Then one of the facilitators remarked that the manager was planning to stop the newsletter for River View. Again, everybody started to talk at once. Apparently this was something affecting the residents. They all made clear that they didn't agree with that, that's not what they wanted. The facilitator continued by telling them that the manager concluded that the residents didn't need a newsletter. The residents felt surprised. They were not asked for their opinion.

The facilitator intervened and asked the group: "Who wants to keep the newsletter?" All residents raised hands. "Maybe there's not enough input for the newsletter, maybe they are short of writers?" the facilitator continued. One of the women responded, looking at one of the group members: "You can write, Hans. Your stories are very beautiful."

The facilitator once again tried to go back to the subject of "being informed". He asked: "What kind of information do you want in the newsletter?" He asked all the residents in turn. Four of them noted personal information; others wanted information from management on the board about developments in the house. One of the residents concludes: "It doesn't matter what we bring to the fore, they will not listen to us."

Here we can see that the residents themselves came up with ideas for improvements. At the same time, the group was astonished to hear about the end of the newsletter. Once again, they felt disempowered. This also influenced the feelings of the facilitators. When they looked back on the meeting and reflected on the process

together with the researcher, they expressed that they doubted the feasibility of the plan.

### *Sharing concerns with the manager*

The group and the facilitator then decided to talk to the manager of River View about the experienced lack of information and about all the possible solutions they had considered. The manager was willing to have this conversation, but at the same time, she raised some doubts about this meeting. She did not want the meeting to be a matter of questioning and answering: she wanted to have a 'real talk' about the issues. She did not want a repetition of the past and the way she experienced the resident council meetings. Obviously, she also felt disempowered by former experiences.

The meeting was arranged and one morning, three residents of the group and the facilitator met the manager. They talked about their concerns and their feeling of lacking information. They also mentioned the solutions they had thought of. They talked about the newsletter and the rumour that this would disappear. The manager explained that the newsletter was only to be given a new format and that she wished for more input from the residents themselves.

After the meeting, the manager expressed her appreciation for the efforts of the group. She was also enthusiastic about the fact that the residents thanked her for arranging nametags for all the professionals, as they had requested at an earlier stage. The manager experienced something positive instead of only negative noises, as during former resident council meetings. She also noted that the residents were taking care of each other in the group and of other residents in the house. She was enthusiastic about the way the conversation had developed in a positive way: she experienced the meeting as a dialogue. She explained: 'I'm positive about the meeting. We, the residents and myself, worked together and joined together instead of my former experiences with the resident council. It was not just a question and answer game'.

The manager agreed with the plan of the residents to purchase a notice board to share information. She asked the residents to develop the plan further. Together with the facilitator, in the next meeting the group talked about the content of the information on the notice board. Besides important messages from staff meetings and from management, the residents wanted personal information about all residents on it (new residents, birthdays, wedding anniversaries, residents who had passed away).

### *The response of the professionals: Two worlds apart*

The facilitator then brought the wishes and plans to the team leaders, because they played an important role in supplying information to the board. The facilitator passed on an e-mail to the team leaders on behalf of the residents. In this e-mail, he

introduced a summary of the wishes expressed and suggested solutions of the residents and asked the team leaders to meet the group.

It appeared difficult for the facilitator to arrange a meeting with the team leaders because of their full agendas. They did not seem to prioritize this meeting with the residents. The result was that the team leaders gave a response on the issues and plans by e-mail. The conclusion was that the team leaders did not want personal information about the residents on the notice board. One of the reasons they gave for this was the decline in the mental and cognitive state of the residents. Also, the team leaders questioned the ethical appropriateness of the information on the board in relation to the privacy of residents.

The team leaders responded only to the solutions that were brought up by the residents. They were only informed about the outcomes and the solutions of the residents; it was not possible for them to know the reasons and values driving these wishes. It was not made clear that the residents wanted to be informed about what was going on in the house and that they wanted to have a voice. Residents also wished to have a connection with each other and have personal contact. The professionals responded from a system world perspective. Their arguments were strategic: instead of seeing 'being informed' from a relational point of view (connection), they came up with privacy issues. At the same time, they expressed doubts about the ability of the residents to understand and respond to the information and they concluded that residents, therefore, should not have this information. This is remarkable, given that a group of residents suggested this themselves.

The facilitator felt uncomfortable and disappointed about the situation because the professionals did not support the plans of the residents. He brought this message to the meeting of the group. He told the group that the professionals did not want personal information being spread on the board. He also told them the supporting arguments: more and more residents face cognitive decline and it was assumed they did not bother about this kind of information.

One of the residents responded: 'When we put no personal information like birthdays, anniversaries and people who have died on the board, you miss a lot. It's part of the community, it is part of life'.

Other residents agreed and expressed that things become so impersonal and distanced. One woman continued: 'One of my acquaintances lives here. She's sick and had to go to hospital. I visit her there. I want to know when somebody is ill and has to go to hospital'.

The residents started to stress the important meaning behind sharing personal information for the feeling of community in the house. They became very explicit and clear about the underlying value of sharing personal information: it leads to feelings of knowing each other more, belonging to a community and staying in touch with each other. Also, some residents expressed feelings of disappointment. The way the professionals responded to their plans was a confirmation of their feeling that they did not have a say and that they were not taken seriously. At the same time, the residents did not dismiss the point of view of the professionals.

They spontaneously started thinking about alternative ways to pass on personal information. But then again, the same objections to the plans could be raised by the professionals. The facilitator felt puzzled and did not know what to do. How to bring these two parties together? The process had reached an impasse. These feelings were shared with the researcher, during one of the reflection meetings after the group meeting with the residents.

### *The manager's view: An unfinished project*

The researcher (first author) then arranged a meeting with the manager to talk about the process so far and to reflect with her on what had happened. The manager was not satisfied with the way it was working out. The enthusiasm she had felt at the beginning seemed to be slipping away. She noted that there was no real, open and substantive conversation with the residents. In her opinion, the process had not come to a conclusion; things had not been worked out yet. Although at the start of the project it seemed that she was motivated by instrumental reasons (forming a client council again to avoid negative financial consequences), she now seemed to value the dialogue and she searched for the values behind the practice improvements that were brought up by the residents. Together with the researcher, she concluded that there has been no meeting so far between the residents and the professionals involved. They needed to enter into a dialogue. The manager talked to the facilitators and once again they started to arrange a meeting. This time, with the help of the hierarchical power of the manager, they succeeded.

### *Two worlds coming together?*

On a rainy afternoon, the residents, the facilitators and the professionals (the manager and the team leaders) came together in one of the meeting rooms in River View. When the meeting started, one of the residents spontaneously started to tell a personal story. He marked that there is a big change when you move to a residential home:

You have to leave your house and your familiar environment. You have to say goodbye to a certain part of your life. And then you come here and everything is new and you feel like a stranger. You don't know anybody. That's what we all have to face in the beginning.

He continued with a plea for a welcoming committee, a topic that also came up in one of the group meetings, and a way of getting to know other residents. Another woman responded to that: 'That's the way it should be, bringing the residents into contact with each other'.

Another resident in the group explained that they wanted a notice board to stimulate contact and the involvement of residents with one another. By sharing

personal information on the board, the residents believed this could be supported. After a while, one of the team leaders said:

What I hear is that the residents want to have more contact with each other, they want to be more connected with each other. We can realize this in another way than putting a notice board on the wall. We can arrange coffee mornings on one floor. This can stimulate an informal way of meeting each other and during these meetings personal news can be shared.

The residents reacted positively to this proposal. Then the manager mentioned that she was concerned about the representativeness of the group: 'This group of residents has these ideas, but what about the other residents?' The group answered that they did not know exactly. They had to ask the other residents. One of the group members suggested: 'We could make a questionnaire and ask the other residents'.

The manager expressed concerns about that: 'Are the other residents willing and able to fill in these questionnaires?' By talking about it and sharing ideas, the residents and the professionals came to a shared solution: the group would make a list of questions and they would go to the coffee mornings to meet other residents. By talking to them and having a conversation, they could bring up the questions and hear the opinions and ideas of the other residents. This was also a way of coming into contact with each other and stimulating contact between residents.

The group of residents and the professionals finished their meeting. New arrangements were made and new plans were born. Outside, the sun started to shine. Here we can see that, spontaneously, one of the residents started to tell a personal story that expressed the underlying values of the wish for personal information on the information board. Now, the professionals understood the reason. There was common ground to talk about the improvements suggested by the residents. One of the professionals tried to finish the former discussion about the information board and tried to open up the conversation, starting from the underlying value of seeking connection. The exchange of ideas and values led to new openings and possibilities. This could only happen when everybody listened to each other and opened up during the dialogue.

## **Discussion**

In this article we have described our learning experiences of what happened in residential care home River View when we tried to enhance the collective involvement of the residents by using a PAR initiative, the PARTNER approach. This approach is inspired by responsive evaluation and tries to involve all people in a certain setting in order to create a communicative space for dialogue and learning from each other's perspectives. With the example of River View we wanted to shed light on the dynamics of this process, in order to learn lessons about using PAR in

a residential care home. We used Habermas' theory as a lens to look at what happened in order to understand the dynamics of the process of involving residents in the context of a health care organization. The PARTNER approach started off in the lifeworld of the residents of River View. The assumption was that dialogue could bridge the gap between the lifeworld of the residents and the system world of the organization by creating mutual understanding and by stimulating partnership between residents and professionals. Hence, we strived for the facilitation of this process by professionals of River View as facilitators, while we as researchers were more at distance and took on the role of facilitators of the facilitators.

From our findings we can learn that the gap between lifeworld and system was not bridged easily. Residents started talking about their experiences in the lifeworld. In a short while, with the help of the facilitators, the residents were able to express themselves and to explore their issues together. A communicative space for residents seemed to be created. The main issue that came up in the group of residents was the fact that they were not informed properly by the management and by professionals and felt that they were not being heard. As described in our findings, the residents also mentioned that they missed the connection amongst each other. Remarkably, when the residents started talking about solutions, they came up with ideas that fitted the system world of the organization such as a notice board, putting information in the weekly newsletter and nametags for the professionals. It seemed that residents had become part of the system world as well and thought about solutions that fitted the system. Also, the facilitators guided the group into thinking in terms of system solutions like 'exchanging information'. The facilitators felt as if they were caught between the narratives and emotions of the residents and the system of the organization, and fell back on the discourse of the system. Also, the facilitators took the lead in the process and unintentionally remained in control.

Another pattern that we noticed was that the facilitators were not able to arrange a meeting between the residents and professionals because the professionals did not prioritize this meeting in their busy schedule. In order to get them on board, the facilitators then typically used instrumental and strategic ways of communication, like e-mails. In the case presented, this led to a strategic response by the team leaders, again through an e-mail. Furthermore, the ideas of the residents were put aside easily with privacy arguments from a system approach. Lifeworld and system remained separated and it seemed that residents, facilitators and professionals used different 'languages' and held different assumptions. It was remarkable that the residents tried to speak the language of the professionals and tried to find solutions that fitted the system world. This language did not, however, provide the right words to express their experiences and problems. It appeared difficult to find common ground between residents and professionals and to understand each other. In fact, creating a communicative space in order to stimulate dialogue between residents and professionals seemed not possible.

Although the intentions of the manager at first seemed to be driven by meeting formal rules (arranging a client council in order to meet legal guidelines), during

the process she became intrinsically motivated and was not satisfied with the outcomes. The manager was aware of the importance of a meeting with team leaders and used her power strategically to arrange this meeting between residents, team leaders, the facilitators and herself. In this last meeting, we saw the impasse was opened up. Then everybody could have a say and was listened to. Spontaneously, one of the residents started to talk about his personal experiences and told his story. Then the professionals understood him and that was the springboard for talking about underlying values and for dialogue. Then the horizons of the residents and the professionals broadened and new ideas and solutions were born in a communicative space (Gadamer, 1960; Widdershoven & Abma, 2007).

Former research showed that in formal client councils there was a gap between lifeworld and system world (Baur & Abma, 2011). In our attempt to search for alternatives, we were aware of the need to find ways to overcome this gap. Our assumption was that PAR and responsive evaluation have the ability to open up communicative space and bridge this gap. In our effort to do so, we have learned that bridging the gap between lifeworld and system still was not an easy task in the context of residential care home River View. We have seen that lifeworld and system are not separated in a dichotomy but are intertwined. All people involved (residents, manager, professionals, facilitators) meander between both realities. The system is often dominant in this context and, in terms of Habermas, colonizes the lifeworld. In this context, the expert knowledge of professionals is highly valued and there is a tradition of evidence-based evaluation (Abma et al., 2016; Abma et al., 2019), with less value for the lived experiences and experiential knowledge of clients and patients (Abma, 2018). This is related to power (Wicks & Reason, 2009). Remarkably, this leads to feelings of disempowerment of all persons involved at certain times.

In our process we have focused explicitly on creating a communicative space for residents in order to support them in expressing themselves and the opportunity to let their voices be heard. This was important for us, because we strived for participation of all those involved in the context of the residential care home. Especially the involvement of the residents was important because often, older people's voices are marginalized, especially in a context where expert knowledge is highly valued. We have shown that the residents were able to collectively express what matters to them. In retrospect, we should have given more attention to the group of professionals (team leaders). They reacted from a system logic and experienced time constraints; they did not give priority to a meeting with residents. Creating a communicative space and opening up dialogue around the issues of the residents could have opened up more understanding and an exploration of underlying values and assumptions from the perspectives of themselves as professionals. From this, creating opportunities for dialogue between residents and professionals might have been more easy.

From our experiences we can derive that our PAR using the PARNTER approach in order to enhance the collective involvement of residents and bring change was a complex process. This case example (but also in other PAR projects

with residents) is situated in an institutional context in which we had to deal with strategic behaviour and existing power structures between professionals and management on the one hand and older residents on the other hand. Furthermore, and intertwined with this, the rational logic of the system world was dominant and present everywhere. This rational logic was highly valued and overruled the narratives stemming from the lifeworld (Abma, 2006). In River View the residents expressed emotions about not being heard and the fact that they were not taken seriously. But emotions are not considered rational and do not fit the discourse of the system world, and therefore claims were not counted as valid, while emotions can be a driving force for involvement and dialogue (Nussbaum, 2003).

We can find these notions of power, discourse and language in the work of Kemmis (2008), who argues that trying to transform practices by PAR is always related and confronted with 'cultural-discursive, social and material-economic fields' that lay besides the individual (p. 126). He also mentions a connection to language:

understandings and the languages and discourses in which they are expressed are themselves already galvanized by relations of work and power, and they are the vehicles of work and power relations (as also amply evidenced in the work of Foucault). (p. 127)

From our study we can learn that, although people want to strive for a situation in which all involved are valued and all voices are heard, power dynamics and hierarchy can play a role through language and discourse (Fricker, 2007). As we have shown, the stories and emotions of the residents (their experiential knowledge) were easily put aside, while the value of the expert knowledge of professionals was uncontested. We therefore recommend that researchers are aware of this power dynamics and reflect on these processes, often hidden in language and discourse.

Besides the connection to this critical approach of PAR, we also underline the notion of Maurer and Githens (2010) of the importance of dialogue in AR. From our experiences we also learn that striving for dialogue (coming to mutual understanding through sharing perspectives of all involved) (Gadamer, 1960; Widdershoven & Abma, 2007) has not been easy and takes a lot of effort. At the same time, we consider this effort as valuable, because dialogue can bridge the gap between system and lifeworld. In dialogue, all those involved explore and share their own underlying values, assumptions and meanings, leading to an increase of mutual understanding (Abma, 2018; Abma et al., 2016; Snoeren, 2011). Not just a dialogue on what needs to be done in order to realize a certain goal (strategic behaviour), but communicative action where participants are prepared to step back, reflect and ask 'what are we doing'? (Kemmis, 2008, p. 127). In our case example, we saw an opening when this dialogue occurred. As researchers we see ourselves operating in the interference zone between lifeworld and system (Kemmis, 2008; Kunneman, 1996). Dialogue can be the vehicle in this niche,



because in this communicative space people cannot stick to superficial validity claims, but have to reflect on more underlying moral values, assumptions and meanings. Here they can find a common language that contributes to understanding each other. Maurer and Githens (2010, p. 289) state that PAR projects especially in organizations with strict hierarchical structures can contribute to more equitable relationships. We agree on that, but at the same time we see a paradox here. Dialogue can have a fruitful contribution, but takes time. And it is exactly time constraints that stood in the way of prioritizing such a process (Chenoweth & Kilstoff, 2002; Jacobs, 2010; Mead, 2008).

We conclude that striving for the collective involvement of clients in residential care organizations is a complex and delicate process. It is not taking place in a vacuum, but is embedded in a socio-cultural, political context, related to power asymmetries. Our experiences with the PAR approach, called PARTNER, in River View have made this more explicit. In order to stimulate collective involvement of residents in a health care organization, dialogue between residents and professionals must be arranged carefully. Dialogue is not just a method or tool on what needs to be done in order to realize a certain goal (strategic behaviour), but a praxis of communicative action in which reflection of participants is important (Kemmis, 2008, p. 127). In this dialogue, attention has to be paid to emotions and processes of power, sometimes hidden in the discourses and languages used. Such dialogue can generate practical moral wisdom, what Aristotle called *phronesis*; this is the kind of knowledge that is linked to what it means to be a good doctor or a good nurse. It is not knowledge *about* something (instrumental knowledge) but knowledge linked to personal moral development (Abma et al., 2016).

A facilitator can foster this dialogical process by playing the role of interpreter. In this PAR initiative, the PARTNER approach was facilitated by people of the organization. We have learned that this was not an easy task for them. They were also part of the political, socio-cultural context is the residential care home and had to operate in it. Here, our researcher's role of supporter of the facilitators was valuable. We were like a Socratic guide, starting up a reflection with the facilitators. From our case example, we have learned that it was not only important to help the facilitators through the different steps and stages of this PAR, but also to reflect on the process itself and ask questions referring to underlying values and make hidden processes of power visible. This was also the case when the manager expressed her dissatisfaction about the fact that there was no meeting possible between the residents and team leaders. Reflecting on this, together with the researcher (first author), made her aware of the importance of this meeting and helped her to become aware of the importance of such a meeting in order to stimulate dialogue. At the same time, this role of Socratic guide was complex. I (first author) had to meander between proximity and distance, being involved and step back and reflect.

To stimulate collective involvement it is necessary to strive for common ground and a collective language has to be found to really understand each other. By taking this as a starting point, professionals can use a language that enables

them to understand what residents are talking about. This is not the bureau-professional language of information exchange, privacy and disabilities, but an everyday language that is open to and able to express important personal values like compassion, connection and being part of a community. These can pave the way to new solutions and a practice in which the voices of all those engaged in a practice are valued.

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