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Conflicting demands and the power of defensive routines in participatory action research

Gaby Jacobs
Fontys University for Applied Sciences, The Netherlands

Abstract
Participation has been of ongoing interest in the field of action research and the New Health Promotion movement, but it is not without tensions and problems. This article presents the challenge of containing the conflicting demands of personal empowerment, practical advancement and theory building in a community-based participatory action research project 'Aspiring to Healthy Living in The Netherlands'. A Participatory Action Research (PAR) methodology was chosen because of its contribution to empowerment of the community of older people, which was one of the project goals. Besides that, the project aimed at the development of an intervention program for encouraging healthy living amongst older people in The Netherlands and contributing to the knowledge base on healthy living, by analyzing narratives from the participants. However, when time pressure rose, the empowerment goal started to collide with academic and practical aims, and the dialogue within the project team became obstructed leading to a return to the traditional routine of applied research and the accompanying power relationships, with implications for the learning in and about the project. This article starts with a short review of the literature on community participation in health research and the challenges of learning participatory action research, followed by a description of the PAR project and the process of participation, using the ladder of Pretty as a tool to highlight different levels of participation in different project stages. By using the theory of organizational learning developed by Argyris and Schön (Argyris, 1993; Argyris & Schön, 1978), insights will be provided into the attempts of a relatively inexperienced team to create a participatory and dialogic research project, and the problems in keeping reflection and learning going within a context of external pressure.

Keywords
action research, empowerment, learning, participation, reflexivity

Corresponding author:
Gaby Jacobs, Lector (professor), Fontys University for Applied Sciences, The Netherlands, Prof. Goossenslaan 1–01, PO Box 90900, 5000 GA Tilburg, The Netherlands
Email: g.jacobs@fontys.nl

> How, on the one hand, the complex agenda for participation is achieved when, on the other, the pushes and pulls of traditional research appear to mitigate against genuine participation, remains open to question. (M. Ray, 2007, p. 86)

Participatory approaches in health promotion

The New Health Promotion emerged in the 1980s and is characterized by the inclusion of social and economic determinants of health, the move away from a focus on individual lifestyles towards collective and political action for health, and the participation of the community in identifying health needs and strategies as a key in empowerment and health promotion (Laverack, 2004; Robertson & Minkler, 1994). This movement radically differs from the top-down approaches that were common before that time, in which professionals defined the problems and needs of communities and took control over actions.

Participation in health research

Participatory Action Research (PAR) and Community-Based Participatory Research (CBPR) are two examples of participatory research approaches that have gained increasing popularity within the health disciplines since the late 1980s. Although there are many versions of these methodologies, in general both PAR and CBPR refer to the participation of community members and researchers (and also other stakeholders, e.g. policy-makers and practitioners) in a joint process of research and action to which all contribute equally and in which co-learning takes place, and both provide the opportunity to give voice to communities and increase control and ownership over activities that improve the health and lives of disadvantaged communities (Minkler & Wallerstein, 2003; Heron & Reason, 2001; Stoecker, 1999).

Community participation in health promotion is defined as 'a process whereby community members take part in the identification of their needs, setting priorities, identifying and obtaining means to meet those priorities, including the development, implementation, and evaluation of those means in terms of their outcomes' (Koelen & Van der Ban, 2004, p. 138). Although at first reading this could seem a pretty straightforward description, in practice the concept is a buzzword. It is used frequently and within a diverse array of contexts but without explanation; consequently its meaning has become rather blurred (Chiweza, 2005).

To relieve some of the confusion around community participation, instruments have been developed to distinguish different levels of community participation and to screen projects on their participatory characteristics. Examples are the guidelines for participatory research in health promotion (Green, n.d.), the framework developed by Boyce (1993), and the ladder of Pretty (Pretty, Guijt, Thompson, & Scoones, 1995)[1] which describes seven stages in participation (see Table 1).

Table 1. The Ladder of Pretty

7. Self-mobilization	Community members set their own agenda and organize for action. Professionals have a role in the background, are facilitative and supportive but only if asked.
6. Interactive participation	Professionals and community members work as equal partners in defining the problems or needs and the strategies for change. There is a sharing of knowledge and valuing of 'local' or 'lay' knowledge. Professionals facilitate and support the process.
5. Functional participation	Community members are involved in decision-making and the development and execution of programmes or activities. Professionals are in control and take responsibility for the process.
4. Participation by consultation	Community members are asked to give their opinions on the program plans. The professionals decide what to do.
3. Participation by information	Community members are informed in an early stage about the program plans and are given the opportunity to ask questions.
2. Passive participation	Professionals are in control of the program; community members are informed about the program.
1. No participation	Community members are not informed about the program, only about the activities for which they have been recruited.

These tools suggest that participation is an unambiguous concept, which can be present to a large or smaller extent. But a closer look at, for example, the different stages of participation on the ladder of Pretty, reveals the different meanings given to participation within one and the same instrument. Whereas participation on the lower levels is instrumental, on higher levels it has democratic and empowering characteristics. This is in line with the literature that reports different perspectives on participation, for example, a utilitarian perspective in which community participation is a method to acquire inside information and support from the community in order to develop or implement health promotion interventions (Green & Mercer, 2001), and an empowerment perspective that aims at changing the power structures and in which participation is a goal in itself (Stephens, 2007).

M. Ray (2007) has distinguished traditional, consumerist and democratic participatory approaches. In the first, participation is shallow and limited to the involvement of community members as sources of information. This sort of participation is generally located at the lowest steps of the ladder of participation, steps 1 to 3. Consumerist approaches are based on an instrumental rationality (Habermas, 1984) and market ideology that treats participants as instruments to achieve predefined goals. These approaches do not exceed levels 4 and 5 on the ladder of Pretty. Democratic approaches, by contrast, emphasize the empowering potential of collaboration and collective action: traditional power arrangements in

health research, policy or practice are changed. These so-called transformational approaches are characterized by a communicative rationality (Habermas, 1984) or dialogue (Freire, 1970) and high levels of participation, that is, levels 6 and 7 on the ladder of Pretty. A democratic PAR begins with a research topic that 'matters to, and ideally comes from, the community itself, and involves members of the community in the research process. They are not simply objects of study, but co-contributors to knowledge and understanding' (Holstein & Minkler, 2007, p. 23). Dialogue and reciprocity are key concepts in this approach.

Challenges in conducting PAR

Dialogue in PAR is seen as 'occupying a central position (. . .) by making it possible for participants to create a social space in which they can share experiences and information, create common meanings and forge concerted actions together' (Park, 2001, p. 82). Dialogue is important in creating collaborative relationships between researchers, communities and other stakeholders, as a continuous process of conversation and exchange. However, in this process 'understanding and misunderstanding, agreement as well as disagreement are intertwined and always at work' (Benhabib, 1992, p. 198), thereby making collaborative work challenging and demanding. These difficulties become manifest in the many papers in health and nursing journals in the last two decades. The reviews conducted by Zakus and Lysack (1998) and Israel, Shulz, Parker, and Becker (1998) mention difficulties in defining the community, the building of trust and respect within the partnership, the sharing of power and control, institutional demands, conflicts stemming from different perspectives, and last but not least the time-consuming nature of participatory research.

Maiter, Simich, Jacobson, and Wise (2008) have pointed to the importance of the creation of and investment in reciprocal relationships in a CBPR project in achieving its goals. This means that power issues should be explicitly addressed and settings created where meaningful exchanges can take place, as well as an open discussion of the different benefits involved for different parties involved in a project. In addition to that, the limitations of reciprocity caused by institutional demands should be faced, and plans should be made to address these.

The lack of congruence between the philosophy of participation (and reciprocity) and practical and institutional limitations is discussed in more depth elsewhere in the literature. For example, Busza (2004) draws our attention to the tension between the research goals and social objectives of participatory action research, which in her participatory project with sex workers resulted in the decision to reduce in-depth interviewing and provide opting out possibilities for the women. Others point to the difficulties practitioners face implementing a bottom-up approach in a context which is primarily top-down and bureaucratically organized (Jacobs, 2006). The existing power relations in society and institutional arrangements will inevitably infiltrate a project, and can lead to splitting of tasks or attributing good/bad feelings to different members within the project group when anxiety arises. In order to create coherent

and reciprocal relationships, trust needs to develop, which only comes from relationships built over time (Ospina et al., 2004).

In addition to that, educators have commented upon their practice of teaching action research, pointing to the difficulties involved in learning the doing of action research. They stress that doing action research is not about the simple acquisition of knowledge and skills, but a way of thinking and an attitude, which is not so easily acquired: 'All of a sudden, they [students in action research] are dealing with a non-linear world where they confront the social psychology of participatory methods, finding meaning in action, and getting up close and personal with the data' (Sankaran, Hase, Dick, & Davies, 2007, p. 296).

In many publications, this process of learning is pictured as life-changing or transformative. The doing of action research is seen as the best way of learning it, and the importance of time for reflection and dialogue and the availability of support in this development process is stressed, as well as awareness of the power relationships that impact upon the learning (Kur, DePorres, & Westrup, 2008; Sankaran, Hase, Dick, & Davies, 2007; Taylor & Pettit, 2007).

Barriers to learning consist of pre-existing conceptions of research and professional identity that hinder the researcher to act collaboratively (Kitchen & Stevens, 2008; Kur, DePorres, & Westrup, 2008; Sankaran, Hase, Dick, & Davies, 2007). This is especially true for the 'vampire that never dies': the positivist research paradigm (Greenwood, 2007). This is reflected in the inability of organizations to work according to the democratic principles that they preach (Taylor & Pettit, 2007). Researchers need to learn to deal with the ongoing conflicts, challenges and frustrations the positivist paradigm poses in practice, because the mainstream academic or professional context is often characterized by lack of support and prestige in doing action research (Greenwood, 2007; Sankaran, Hase, Dick, & Davies, 2007).

The literature base shows that democratic PAR for many is entering an unfamiliar domain, and even if it is not, then it still requires the courage to risk one's professional identity within an institutional context that offers little or no support. Learning the doing of PAR for researchers entering this new domain is transformative; however, there are many pitfalls on the road.

The project Aspiring to Healthy Living

In the following, the experiences in a PAR project with older people will be discussed. First, I will introduce the project, the project team, the evaluation of the participation process, and my role in it. In the next sections I will describe and discuss the main themes of the evaluation.

Background to the project

The percentage of older people in the Dutch population is now about 20 percent and still on the increase and so is the population of older immigrants, such as the Moroccan guest workers who immigrated to the Netherlands in the 1960s

and 1970s. In 2008, approximately 75,000 men and women of Moroccan nationality were living in The Netherlands (of a total population of 16 million people) and almost one third were over the age of 55. Although this number seems to be small, it is expected to increase sharply in the next decade. The majority of Moroccan people (and other immigrant groups) live in one of the four big cities: Amsterdam, Rotterdam, The Hague and Utrecht. Moreover, there are some important differences in actual and experienced health between older Dutch and older Moroccan people; the lower socio-economic status of the latter is an important factor in this. Knowledge of older people's diverse experiences and meanings of health is important when developing a multicultural health policy and health promotion practice, and therefore the Dutch government commissioned ZonMW, the Netherlands Institute for Health Research and Development, to give special attention within the program Healthy Living (2000–08) to the participation and empowerment of specific target groups, such as older people and ethnic minority groups.

One of the projects funded within this ZonMW program was the Aspiring to Healthy Living (AHL) project. The project aim was to develop insight into healthy living of older Dutch and Moroccan men and women with a lower socio-economic status, and to develop activities to promote their health and empowerment by giving them more control over factors that influence their health and lives.

The project team

The project team consisted of a heterogeneous group of people. First of all there were eight older people (50 +) with a low socio-economic status; four of them were born in The Netherlands and four of them emigrated from Morocco between 20 and 30 years ago. They were recruited from two different geographical communities in Rotterdam, which is the second largest city in The Netherlands, and already were known with the municipal health agency that was a partner in the project, because of their volunteering work within these neighborhoods. The older people were not seen as representatives of their community (see Stephens, 2007), but as a linking pin to help include the wider community's voices in the project by conducting interviews and feeding back the results.

Working with the community members were two health practitioners (one from the municipal health agency, the other from a national health agency specializing in the development of multicultural health practices); three researchers from the university including myself, all with a social and clinical/health psychology background; and the project manager (a university professor).

All project members were paid for their contribution: the health practitioners and researchers were bought out from other work commitments for one day a week, and the older people were paid on an hourly basis on an average of four hours per week. The decision to pay the older people was part of the motivation to establish an equal partnership with the older people as co-researchers, co-developers and co-educators, but as researchers we were conscious of the possibility that payment could also attract extrinsically motivated community members. This fear

was reduced by the interviews with the community members at the start of the project; these made clear that the community members were primarily motivated to make a difference in the health of their communities, and some even strongly emphasized that they were not willing to take part if the research would lead to 'more paperwork instead of real change'.

Evaluation of the participation process

I was involved as an academic researcher in the project, and will reflect on the process of working collaboratively and the hurdles we as a project team had to overcome. I will use interchangeably the first-, second- and third-person voices to mirror the complexity of the positions within the project and because taking an ex-centric position (third-person perspective) to the project enables critical reflection (Brockbank & McGill, 1998). The aim of this article is not simply to let my own voice speak, but to use different sources of data to provide a more nuanced and multi-vocal perspective on the process of participation. The 'we' may refer to the development group (DG) consisting of the project manager and myself, the whole project team (PT) including the community members, the partner group (PG) consisting of researchers and practitioners, or the researcher only group (RG).

Data about the PAR process have been collected in two ways, prospectively and retrospectively, and both by myself and by external researchers. First of all, I collected data by using the minutes of all meetings, emails sent within the project team and between the project team and external parties, and other documents produced by members, such as interview guidelines, logbooks and selection criteria for recruitment. Besides that, after the project was finished, semi-structured interviews using a topic-list were held with all researchers (including the project manager and myself) and health professionals, and a focus group discussion with the community members in the project team. The interviews with the researchers were conducted by a researcher who had not been involved in the project (as data for her own research project); the focus group with the community members as well as the interviews with the health professionals were held by another external researcher as part of the formal process evaluation.

The external researchers and the project team were not able to be actively involved after the project had finished, but they gave permission to conduct a thematic analysis (Braun & Clarke, 2006) on the materials and were willing to comment upon the findings. I was interested in the individual experiences of the process, the meanings given to it, and the things unsaid during the project, using the qualities claimed for PAR – participation and dialogue – as heuristic concepts, and the ladder of participation of Pretty et al (1995) as a tool to trace the development of participation in the course of the project. I discussed my first rough analysis with the external researchers. The themes did not change in the process of collaborative interpretation, but the nuance and openness in the description of the themes did, and this contributed to the validity of the research.

Participation in the Aspiring to Healthy Living project

The project took place in three stages: 1) the preparation stage, 2) the narrative stage in which stories from older people were collected, and 3) the action stage of developing an intervention program.

Stage one: The preparation stage

In the first stage of the project we (DG) were looking for funding and collaboration opportunities with practitioner organizations, and wrote up the project proposal. The project manager and I had taken the initiative for this project and developed its outline, and in consultation with others made the choice for PAR. The reasons for doing so were mainly ideologically motivated. Although we (DG) had not (yet) conducted PAR or CBPR, we had familiarized ourselves with this approach by reading into critical gerontology (e.g. Bernard & Scharf, 2007) and the New Health Promotion that encourages partnerships between researchers, communities and practitioners. We (DG) wanted 'to move out of the comfort zone' (R. Ray, 2007) and involve the 'subjects' of our study – older people – in our research project, not only to understand what healthy living means to them, but also to support them in improving the conditions that contribute to their healthy living. Our focus in PAR therefore was both on obtaining theoretical insights as on bringing forward (personal and social) change processes (Reason & Bradbury, 2001).

Besides that we had strategic reasons for taking a PAR approach. PAR was in line with the funding body's requirements to involve the community in research and practice but as it was not a familiar approach in Dutch health promotion, we (DG) expected that it would help our research proposal to 'stand out from the crowd', thereby increasing our chances to get funding. Therefore, we (DG) described the project as a cyclic and iterative process of reflection and action (Freire, 1970): generating themes, collecting and analyzing data, taking action, reflecting on that action and generating new themes, and so on. However, in order to receive funding the reviewers suggested a more linear approach. Therefore, roughly two stages were built into the project, each allowing for smaller cycles of reflection and action: a narrative and an action stage.

More importantly, throughout the development of the proposal, we (DG) felt the tension of writing up a PAR project before the participation of older people was actually sought. This is not exceptional though, and we comforted ourselves with the thought that community participation to a high degree in all project stages should not be seen as the golden rule (Stoecker, 1999) but as an aim to strive for. It is one of the paradoxes of PAR that in order to receive funding within a limited time frame, participation of community members and other stakeholders is often necessarily limited. In the literature different solutions are reported to deal with this tension, such as framing the methods chosen as 'containers' for the research within which the participants can decide on the content and direction (Ospina et al., 2004). We followed the strategy to leave the topic of the intervention program deliberately

open, and therefore also the strategies to improve healthy living were yet not determined.

Stage two: Narratives and knowledge building

In the narrative stage (the first year), the central goal was knowledge building on healthy living of Moroccan and Dutch older women and men. The project team collected stories of older Dutch and Moroccan people on healthy living. The study of narratives is both a means to understand personal meaning as well as to promote social change (Murray, 2004; R. Ray, 2007). Central questions were: what does healthy living mean to older people? How do they practice healthy living?

We (PT) decided collaboratively to take the World Health Organization's broad and positive definition of health as the framework, in which health involves biological, psychosocial, cultural, economic and political factors; and refers to a state of well-being and vitality (WHO, 1986). In the stories, the meanings and practices of healthy living were contextualized in the participants' individual life histories and social and cultural positioning such as age, ethnicity, gender and class.

The project team met monthly to exchange views and experiences. The community members dominated the discussions, because we (PG) were keen to learn about the older people's perspectives on healthy living and on the project; and felt a bit wary of enforcing our views on them. This hesitancy to speak one's own voice is also reported in the literature, and becomes a problem if democratic work leads to giving up one's authority (Ospina et al., 2004).

After six months the project manager established subgroups to deal more efficiently with issues of research and intervention development. The researchers and practitioners agreed, and the community members were informed about this change. From then on, the researchers and project manager met separately in the research group (RG) and with the practitioners in the partner group (PG) meetings. In the project team (PT) meetings the community members, the two health practitioners and an academic researcher participated. This change in organizational structure saved time, but also meant that there were no longer occasions for the whole project team to meet and discuss issues of importance to the project.

In the course of the first year, the community members were trained by the researchers to interview and recruit interviewees from the wider communities: older Moroccan and Dutch women from a lower socio-economic background. The interviews were allocated to all project members. However, the interviews conducted by the community members were of very poor methodological quality. Some transcripts covered only a few pages and the answers remained superficial; in other interviews the interviewer did the talking instead of the interviewee. We organized a further interview training, and in the second round the quality of the interviews had improved.

However, the project had lost much time by then and the project manager decided that the researchers would conduct the analysis, although one of the practitioners explicitly and several times expressed a wish to be involved in this as well.

Each researcher took a different perspective (empowerment; meanings of life; health) as a rough conceptual framework. Results and findings that were hard to interpret were submitted to the project team. Due to time constraints we (RG) did not feed back the results to the interviewees, but the input from the community members enhanced connection with the experiences of older people and improved the quality of the interpretation. The feedback meetings were the link between the narrative stage and the intervention development in the next stage, because they showed important topics and strategies for working with older people.

Stage three: Intervention development

In the second year, the action stage, we (PT) used the themes generated in the first stage as input to develop a program for healthy living for the Dutch and Moroccan community of lower-class older people in Rotterdam. Four pilot programs were conducted and evaluated within different communities of older people in Rotterdam.

However, during this second stage the participation of the community members decreased further, taking the form of consultation meetings and some individual interviews with the older people participating in the project group. The project team met less frequently, bimonthly instead of monthly, and in the last six months of the project the team met only twice. The researchers and practitioners now worked more individually, each focusing on their own task: analyzing the material and developing the program. Two community members were involved as peer educators in the program and were interviewed about their experiences by an outside researcher who evaluated the program.

The process of participation

The development of participation of older people in the project can be illustrated by the ladder of Pretty (see Table 1). Participation of the community in the project rose sharply and then declined. In the preparation stage, participation was almost absent (level 2 in Table 1). In the first six months of stage one, the level of participation was high: functional participation (level 5) combined with elements of collaboration and co-learning (level 6). However, after that the participation level dropped and moved to levels 2, 3 and 4. In other words: older people started as active members of the project group in the first year but in the course of that year they turned into a feedback group. In the next sections I will take an insider perspective to give more insight into the dynamics of participation in this project. I will discuss two main themes: 1) participation for what: the clashes between empowerment, academic quality, and practical usefulness; and 2) protection as control. I will use the theory of organizational learning and especially the notion of 'defensive routines' (Argyris, 1993; Argyris & Schön, 1978) to explain the obstruction of dialogue and co-learning in the project.

Participation for what? The clashes between empowerment, academic quality and practical usefulness

At the start of the project, before the community was involved, there seemed to be consensus about the project aims and the importance of community participation to realize them. However, in the course of the project it turned out that participation did not mean the same for everyone and also that different conceptions of participation could be present within one person. The analysis of minutes of meetings and interview material made it possible to reconstruct three different positions in relation to participation.

Empowerment

A first position that was taken was the strong ideological position that advocates empowerment of the marginalized communities of older people in Dutch society as the aim of the project, and participation as the key to realize this. The focus was not so much on results, but on the empowering capacity of the process, and the ideal expressed was to give voice to communities who are unable to speak up for themselves in academic discourse, unless someone mediates for them:

> Right from the start, you will have to, and dare to, and be willing to (. . .) involve these people in your research, as co-thinkers and co-organizers. But then you will have to dare to leave it [the result and process of the project] open – if not, it becomes fake. Then it'll be manipulative consultation, and you already know how you want the meeting to end. And it depends on your brilliant, manipulative skills whether the outcome of the meeting will be what you thought it would be the day before. See, that is not participation; that is fake. Then you will have to present it just like that: you are allowed to give input, but only to a certain extent. Then everyone will know what your intentions are. That is not participation; that is abusing the notion. It is participatory fake.

This quote illustrates the discourse of 'real' participation in an empowerment approach to PAR and the way this is constructed as opposed to the 'fake' participation in an instrumental approach. The empowerment view dominated with two researchers (including myself), but was in a lesser degree also present with the health practitioners and the project manager.

Academic quality

The second position was the scholarly one. In this view, participation was viewed as important because of its contribution to the methodological quality of the research (the so-called member check). Neither a specific ideal, nor the creation of a social relevant outcome (in this case a health education program) was seen as the aim, but

the academic status of the project and publications resulting from it, as is illustrated in the following quote:

> Your article is ... to put it bluntly, judged by what you have done with your perspective in the analysis of the interviews, and not by how the project has been organized. In five years time, nobody will care. But in the meantime what's very important: validity, being representative, correct use of the method.

The focus was on the conventional methodological questions and technical norms for good research and not so much on ideological or moral considerations. This view dominated with one researcher, but it was also present to a lesser degree with the other researchers including myself and the project manager.

Practical usefulness

In the third position, the pragmatic position, high value was attached to the practical usefulness of the project. Members who prioritized this value focused on the practical outcomes and its contribution to health promotion policy and practice, and the community:

> I am glad there are certain practical limits. Otherwise, I think you would loose yourself in realizing your ideals. And then the target group is still left with nothing. I mean, and then five years have passed, but ... Well, that leaves them empty handed.

This view was present in the accounts of the health professionals, the project manager and the community members; to a lesser degree it was also mentioned by a researcher.

The different meanings of community participation only became clear when time pressure increased in the second half of the first year. We (RG) felt we had to choose between an innovative and exciting empowering research approach on the one hand, and the classical standards of doing applied research and being taken seriously within the academic world, on the other hand. Some researchers resolved this by choosing the latter (see the extract illustrating the position of academic quality); I personally kept feeling this tension up until the end of the project, which I expressed in an email to a colleague: 'I would like to find a way to involve the community and do high standard research as well – now it feels we failed on both.'

Protection as control

A related theme that emerged from the data refers to the way power and control is executed within the project. In the first six months of the project, the group was still in their 'honeymoon', bonding and enthusiastic about the project (see Tuckman & Jensen, 1977), but then with the first interview results, reality came in and the threat

of neither achieving the academic nor the intervention targets in one-and-a half year's time put pressure on the participation and co-learning in the project. Time restraints were pushing the project forward to produce visible results, instead of attending to the process and relationships within the project team.

'Protection' of community members

The decision of the project manager to have separate meetings (i.e. the research and partner group) to avoid 'overburdening' project members was agreed upon by the partner group although not wholeheartedly because of the splitting of tasks and responsibilities that previously had been shared. As one of the practitioners argued: 'I now see that it is not possible to achieve full participation: you have to be realistic and look at the outcomes for the funding body as well.'

The community members were informed about the changes, but the details of the quality of their interviews were not discussed out of fear of demoralizing them. As one of the health practitioners said: 'They have put so much effort into this.' Although this prevented the community members from having to receive the bad news, this also resulted in them being excluded from the decision-making and having control over their own interview activities. Not surprisingly then, the community members were very critical of the way participation was conducted in the project: 'The researchers did listen to us, but they didn't do anything with it.' And another member: 'We could offer our opinions, but it didn't really matter... the decisions were made elsewhere and often it was not clear what was decided.'

Two members were quite explicit in saying that they had wanted to be involved more in the project, for example, in developing an interview schedule: 'I wanted to make a contribution.' They referred to the project as their job, indicating the sense of pride and achievement they drew from having a formal working relationship with a university and professional agencies. Not unsurprisingly then, they criticized the lack of clarity and feedback in the interviewing process and in the development of the intervention program.

'Protection' of researchers and practitioners

A similar dynamic was present in the relationship between the project manager on the one hand and the researchers and health practitioners on the other hand. The project manager correctly took primary responsibility for the progress of the project and meeting the demands of the financier. Consequently, she stressed the importance of sticking to deadlines and producing output, thereby making a large appeal to individual project members to deliver on time. However, the researchers felt that the time restraints and participatory nature of the project were hindering the scientific quality of the project, and asked for more time:

> I think the available time [for analyzing the interviews] is very limited. I'd rather take more time. The complexity and slowness of these sorts of analyses are actually

> incompatible with such a project. You want to achieve a certain profundity in your analyses, and show the inner connections and contradictions between things, and the difficulty to reach a new definition [of healthy living]. And it takes a lot of time to do that properly. And the project never stops breathing down in your neck: we want a result right now, then and then it all ends, we still need an article.

The project manager took action to relieve the tasks and ease the work schedule, however without consulting the researchers and practitioners which in turn made them feel left out and not taken seriously as equal partners in the project.

Obstruction of dialogue and co-learning by defensive routines

When time pressure increased, different priorities regarding the participation of community members in the project were presented. The ideological position, aimed at empowerment, collided with other goals of achieving a product of high academic standard or working towards a practical program, both of which did not necessarily involve a high level of participation. We can explain this phenomenon of clashing viewpoints by the notion of 'theories in use' developed by Argyris and Schön (1978) which refers to the tacit constructs professionals (including researchers) hold about the practice they are involved in, and that often unknowingly inform their goals and behavior. These theories in use deviated from the 'espoused theories' within the project team in which empowerment of the community, the aim of developing a practical program, and a high standard piece of research came together. Although we (PG) explicitly wanted to achieve dialogue and participation our actual behavior showed the traces of our old models. An example is the treatment of community members as sources of information in the first stage, without letting our voices speak as well. By minimizing our own voice, we hoped to create a more democratic environment (see Ospina et al., 2004), but in fact we recreated the classical subject – object research relationship. When the first crisis arrived, this pattern strengthened into a protective stance towards the community members. Instead of sharing the challenges of the project with the community members and thereby creating a more egalitarian relationship, crucial aspects of the conditions of the project were withheld. These dynamics of participation can be explained by the unconscious wish to regain control over the research process, a dynamic that is described by Argyris (1993) as a defensive routine. It is defined as 'any policy or action that inhibits individuals, groups, intergroups, and organizations from experiencing embarrassment or threat and, at the same time, prevents the actors from identifying and reducing the causes of the embarrassment or threat' (p. 15).

With sufficient time and the excitement of a new project, we (PG) practiced our newly acquired espoused theory of empowerment and community participation. However, when the situation became more constrained we withdrew to our familiar routines, tasks and roles, thereby protecting ourselves from the anxiety that emerged from the threat of our highly valued goals and strategies. This is a

defensive routine, a shift from a so-called O-II Model back to the O-I Model, automatically created to inhibit the experience of embarrassment or threat (Argyris, 1993). As Salzberger-Wittenberg et al. (1999, pp. 4–5; cited in Hunt & West, 2006) explain: 'The more unfamiliar and unstructured the situation, or threatening to our status as people who know, the more disoriented and terrified we may feel' (p. 174). In other words, our working models or theories in use are emotionally charged and strongly defended, and as its workings are covered up and made undiscussable, actions are not likely to be correctable (Argyris, 1993), which makes transformative learning difficult to achieve (Mezirow, 2000). Indeed, our reaction (Model O-I) was to fix positions, divide roles and form subgroups, and thereby regain control over the process and protect ourselves from the anxiety we felt, without at that time acknowledging that this was happening nor discussing it within the project team. As Argyris (1993) states: 'Once a self-fueling cycle of fragmentation and avoidance [i]s established, it [i]s very hard to stop' (p. 38).

Although defensive routines are very common, Argyris and Schön (1978) have pointed to the destructive effects these have, as they interfere with an open and equal dialogue and co-learning and consequently lead to non-productive working relationships and organizational ineffectiveness. This can be illustrated by a quote from an email I sent to the external researcher after the project:

> I feel that now that the project has finished, and instigated by your research into our professionalism, I start to see the traps we fell into. Before we were always in a hurry; busy with the daily logistics and stuff. And instead of supporting each other in our learning, we blamed each other for failures, repeating the old pattern of talking *about* the others but not *with* them.

Conclusion and discussion

In this article I have described the process of participation in a PAR project for promoting health of older Dutch and Moroccan people in The Netherlands, and highlighted two major challenges in participatory working. These challenges are not unique to action research, and neither are the defensive routines that manifest themselves in all different kinds of projects and organizational processes, as Argyris's work (1993) makes clear. However, they will inevitably emerge within a context of innovation and diversity, when researchers and professionals leave the beaten track to work collaboratively with communities and other stakeholders.

The project discussed is also not a good example of an empowering PAR project, but as such it is not an exception. As Zakus and Lysack (1998) remind us: 'Community participation is a complex and fragile process [and] there are many factors that operate to diminish its success' (p. 6). Most of these factors have been addressed elsewhere but the perspective of organizational learning adds to these insights and can provide useful lessons for other researchers who undertake a participatory project.

Hidden meanings of participation

The different meanings of participation found in this study are supported by the literature that reports on different perspectives of community participation (Green & Mercer, 2001; M. Ray, 2007; Stephens, 2007). Whereas an empowerment working model assumes a high level of participation in all stages (Khanna, 1996), this is not necessary within a scientific or utilitarian framework (Morgan, 2001, as cited in Stephens, 2007; M. Ray, 2007). In empowerment the process is more important than the output, goals and methods are determined collaboratively, and findings and knowledge are disseminated to all partners (Heron & Reason, 2001; Minkler & Wallerstein, 2003). From an academic or pragmatic viewpoint, participation is an instrument for improving the quality of the research or the effectiveness and usefulness of a program for healthy living by laying the path for the planned activities.

However, meanings of participation stay often hidden in the working models employed by practitioners and researchers, and only become manifest in the 'doing' of action research when critical incidents happen, in this case the increasing time pressure and disappointing quality of the interviews. Time demands and related external factors, such as funding requirements, are mentioned in the literature as one of the main challenges of conducting participatory research (Israel, Schulz, Parker, & Becker, 1998; Kur, DePorres, & Westrup, 2008; Ospina et al., 2004; Sankaran, Hase, Dick, & Davies, 2007; Taylor & Pettit, 2007; Zakus & Lysack, 1998). This project showed that time pressure can act as a threat and consequently impact upon the interpersonal dynamics within a project, as it sets in motion defensive routines, such as splitting tasks and withdrawing in familiar roles. The question is how researchers can keep the space open for co-learning, *within* the given time constraints.

Recognizing and overcoming defensive routines

Several publications have pointed to the competencies professionals need for dealing adequately with the interpersonal and political dynamics in PAR (Israel, Shulz, Parker, & Becker, 1998; Minkler & Wallerstein, 2003; Nelson, Pancer, Hayward, & Kelly, 2004). Amongst them are communication skills that foster dialogue and reciprocal relationships (Maiter, Simich, Jacobson, and Wise, 2008). Dialogue is a breeding ground for professional development, because it creates a space for reflection on one's theories in use as well as for co-learning (Brockbank & McGill, 1998). Kur, DePorres, and Westrup (2008) refer to a threefold process: dialogue with self, with peers, and with supervisors or coaches, and show how the opportunity for all three should be actively created within a learning situation. Reflection that follows from such a dialogue then is not checking whether the project is still on track, using set targets and instruments to measure the level of participation, but 'showing ourselves to ourselves or holding up a mirror to ourselves' (R. Ray, 2007, p. 69).

This is in line with the model of organizational learning proposed by Argyris and Schön (1978) and Argyris (1993) in which professionals are asked to inquire into their own interpretations of an event that led to certain actions and reactions, including their hidden assumptions, in order to verify and change them where possible. This inquiry is characteristic for Model O-II behavior and can be conducted individually or – even better – collectively, where disagreements exist as to the right course of action. It will lead to a transformation in thinking and acting, also called transformative learning, in which taken-for-granted assumptions and values are questioned and one's frame of reference becomes more 'inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs, and opinions that will prove more true or justified to guide action' (Mezirow, 2000, pp. 8–9).

Model O-II behavior involves taking a meta-position towards the participatory process and the underlying assumptions, and addressing the power relationships inherent in the relationship with the community and other stakeholders. Participatory inquiry itself is deconstructed by reflexivity on one's openness for and capacity to deal with multiple perspectives. This reflexivity requires a second mirror:

> [W]e look at ourselves looking at ourselves. The important distinction here is that someone or something else – an older person, a reminiscence group, a nursing home – holds up the second mirror. To be reflexive, we need an Other to show ourselves to ourselves. (R. Ray, 2007, p. 69)

Reflexivity is not easy and especially under constraining circumstances beginning action researchers can easily fall into old routines. To avoid this, we need to make sure we have an 'Other' in or beside our project that holds up this second mirror and asks us to look into it. In our project the community members could have acted as such, but time constraints caused anxiety which kept us (PG) from creating a reciprocal relationship.

An external coach would have helped us to recognize earlier the defensive routines that formed the undercurrent of the project and disturbed the participatory relationships, and enable the creation of Model O-II learning environments. This does not necessarily implicate that we would have increased the level of participation in line with the requirements of empowering PAR projects. But it would have meant that in open discussion of all project members, both the benefits and investments of participation on different levels would have been investigated and weighed (see Flicker et al, 2007) as well as the delicate balance between democracy and authority in our project (Ospina et al., 2004).

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Note

1. Similar typologies exist, such as the ladder of Hart (Hart & Bond, 1995; as cited in Shier, 2001) and the ladder of Arnstein (1969).

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Gaby Jacobs, PhD, has a MSc degree in Social Psychology and Gender Studies, a PGCE, and a PhD on Empowerment in Counseling. From 2001 until 2006 she was a lecturer and researcher at the University for Humanistics in the Netherlands, and from 2006–2009 a Lecturer in Psychology at Keele University, UK. Currently she is a lector (professor) at Fontys University for Applied Sciences. Her research topics include amongst others: professional development and learning in (special needs and inclusive) education; community participation and empowerment in health promotion.