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Opening up for Many Voices in Knowledge Construction

Marit Borg, Bengt Karlsson, Hesook Suzie Kim & Brendan McCormack

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Abstract: The key epistemological assumption in participatory research is the belief that knowledge is embedded in the lives and experiences of individuals and that knowledge is developed only through a cooperative process between researchers and experiencing individuals. There are various notions about the nature and processes of participation in this type of research. This paper focuses on specific processes that are used for a "genuine" participation by experiencing individuals as research participants. It also identifies processes that are critical for researchers to engage with, in order to become pro-participatory in their approaches to qualitative research. The paper draws on a particular project as an exemplar—"The Crisis Resolution and Home Treatment Project." This project uses various participatory research processes to elicit and include voices of health-care professionals, service users, and family members. The main objective of the research project is to develop knowledge for new forms of community-based practices for people experiencing mental health crisis. We present the participatory research methodology applied in this research, and discuss two sets of processes used to enhance "participation" in research—one set to encourage and elicit participation by research participants; and the other set to engage researchers in reflection within the participatory research process. This will mitigate the paucity of literature regarding the processes and approaches necessary to make participatory research truly "participatory" both for research participants and researchers.

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1. Introduction

In contemporary discussions of knowledge and evidence-informed practice in health care, limited attention is given to the processes of constructing knowledge especially in terms of knowledge for practice. Issues, such as who is involved in the knowledge construction, with what objectives, and for which audience or group of people, are rarely touched upon. Knowledge for practice is primarily embedded in the knowledge-in-practice, and knowledge construction needs to be generated through what occurs in actual practice. Discovery or generation of knowledge from knowledge-in-practice is difficult without engaging practitioners/actors themselves in its discovery. This is the basis from which a co-operative inquiry is applied in seeking knowledge construction regarding practice development. The basic tenet of co-operative inquiry is participation of practitioners or actors in the research process as co-researchers. [1]

We begin the discussion of key issues in participatory research with an illustration of a research project in which we applied a co-operative inquiry method derived from the work of John HERON (HERON & REASON, 2008). In the participatory research project "Crisis Resolution and Home Treatment" (CRHT) (KARLSSON, BORG & KIM, 2008; BORG, KARLSSON & KIM, 2010) we have emphasized the importance of including many voices in the research process. The main objective of the research is to develop knowledge relevant for new community based practices for people experiencing mental health crisis. In the context of our emphasis on experience-based knowledge, we have included in a variety of ways in the research process a number of key stakeholders, including service users, family members and clinicians. The research has also provided an opportunity to explore processes that enable researchers working with participatory intent to be open to the many views and voices that need to be heard. [2]

This paper presents the specific processes that are being used to enable a genuine participation by the key stakeholders as research partners. In particular we focus on the processes applied to enhance the involvement of mental health clinicians in the research. We also focus on how these same processes are critical for researchers to become pro-participatory in their approaches to research. [3]

2. A Case Illustration of Co-Operative Inquiry—A Research Project on "Crisis Resolution and Home Treatment"

2.1 The research context and research partners

In Norway, like in most western countries, the services for people with mental health problems have gone through major changes over the last decades. Inpatient services have been reduced and non-institutional care expanded. Methods and models of community care are established with the intention of providing sufficient acute care and rehabilitation services within the context of the family and social environment of individuals. One significant recent development is the introduction of "Crisis Resolution and Home Treatment" (CRHT) teams with

the objective of offering an alternative to acute in-patient treatment, and providing assessment as well as direct care (EUROPEAN COMMISSION, 2005; JOHNSON, 2007). More fundamentally, it has marked a shift in the locus of care from hospital to community, with opportunities for understanding phenomena associated with mental health crisis and supporting individuals in crisis situations in their everyday life context. [4]

The objective and implementation plan for this new service was ambitious. The Norwegian Health and Social Directorate targeted the creation of CRHT teams in all 78 DPS (community mental health centers) units in Norway by 2008. This directive is based on international research evidence that suggests CRHT is preferable to and a more effective form of service provision compared with acute institutional care (DIRECTORATE OF SOCIAL AND HEALTH WELFARE, 2006). Although promising developments have taken place in many parts of the country, a telephone survey carried out in January 2010 revealed that CRHT teams were established in only 51 DPS-units in Norway, so there is still much work to meet the Directorates' goal (KARLSSON, BORG & SJØLIE, 2011). [5]

Community mental health care has a long history and has evolved to encompass various service models in practice. The major focus of CRHT teams is to provide appropriate services for acute crisis events in people's homes, calling for the transformation of existing practice models as well as developing a relevant knowledge base. This was the background for the research project that this paper draws upon. The research project's focus and aims were identified based on the key issues that impact on the development of CRHT teams as a component of community based mental health services:

- limited knowledge of how CRHT teams actually work and how it is practiced from the service-provider perspective;
- limited knowledge of how individuals or family members understand and define crisis situations;
- limited knowledge of what service-users experience as helpful interventions in crisis situations;
- limited knowledge of service user views of receiving crisis support from CRHT teams at home, particularly in comparison to earlier experiences of in-patient care. [6]

The main research project with three sub-studies explores questions stemming from these key issues, by examining the CRHT team from three discrete perspectives; (study I) the process of development and implementation of a CRHT team in a local service unit; (study II) the experiences of individuals who have used CRHT services; and (study III) the impact of CRHT teams on macro-level outcomes across the mental health service areas nationally and more specifically in the Health South Region of Norway. The idea of CRHT teams encompasses a shift in practice towards a greater orientation on service-users, emphasizing active participation of service-users and family members in the service provision and the mental health care processes in the everyday life

context (BORG & DAVIDSON, 2008). In study II, of which the focus is on the experiences of service users, a competence group consisting of two family members and three former service users participate in the various parts of the study. Although the intention was that the competence group should primarily work in study II, its activities expanded and the participants also contributed to studies I and III, particularly in discussions and reflections related to the findings. In study II the competence group was involved in the planning of individual interviews, in developing the interview guide, reflections over central themes such as "mental health crisis," the impact of crisis on people's everyday lives, ways of coping with crisis and how to help and support people with mental health crisis in their homes in respectful ways. The competence group also participated in the data analysis in study II. [7]

In Study I, the research addresses how mental health clinicians evolve in developing their new practice in CRHT teams to align with these perspectives. The participants in the study were all members of the CRHT team, consisting of 12 professionals—one psychologist, two social workers and nine mental health nurses (three men and nine women). [8]

This paper presents our experiences in Study I as at present we have the most thorough experiences of knowledge construction over a longer period with the same group of participants. The research context for Study I consists of three components—*primarily* the practice of team members of a local CRHT team, which started in this model of service delivery in 2007 and the team members who are research-participants, *secondly* the researchers of the project (one research manager [3rd author], two senior researchers [1st and 2nd authors], three research fellows and one senior research consultant [4th author]), and *thirdly* the service-users and family members of the competence group that provide inputs into the project. [9]

2.2 The method and its application

Action research can be considered as a family of approaches and practices where the core concern is to develop practical as well as conceptual contributions by doing research with rather than on people (BRADBURY & REASON, 2003). We support the definition of action research used by REASON and BRADBURY (2008, p.1) as a

> "participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities." [10]

Study I of the research project is a prospective case study with an action research orientation derived from a co-operative inquiry process. This is a method appropriate for in-depth understanding and examination of transition and

change, as well as for a description of how knowledge is developed and applied by participants *in situ*. Co-operative inquiry is practiced in a variety of research approaches, and is viewed to be appropriate in action research, especially that based upon a participatory philosophy (KEMMIS & McTAGGART, 2000; SEIKKULA et al., 2006). Action research has been advanced in Norway from the 1960s and 1970s through researchers like LØCHEN (1973) and MATHISEN (1973) and in the last ten years by others (BORG et al., 2010; HUMMELVOLL & SEVERINSSON, 2005), and has achieved a considerable acknowledgment, both nationally and internationally, especially in mental health research. While "traditional" mental health research develops "knowledge for understanding," the focus within action research is "knowledge for action" (BORG et al., 2010; LØCHEN, 1973; CORNWALL & JEWKES, 1995). Co-operative inquiry involves not only the integration of theory with data collection and analysis into practice with participants (KARLSSON et al., 2008), but it also develops new knowledge through the inquiry process itself (REASON, 1994). This aspect is especially critical, as the research project is oriented to developing practice in a rather new model of service, i.e., CRHT. The central issue in co-operative inquiry is to develop a research approach that is grounded in the participants' context and in collaboration with people in that context (HUMMELVOLL & SEVERINSSON, 2005). Researchers and participants as co-researchers work collaboratively in identifying problems, deciding on themes for inquiry, selecting a research design, and designing projects for implementation (KARLSSON, 2004; KARLSSON et al., 2008). In co-operative inquiry, changes in practice run parallel to the research process. As it is crucial for researchers to take an active part in the ongoing change process and not being outside observing the events in this type of research, the research is *with* people rather than *on* people (REASON & BRADBURY, 2008). [11]

Practicing co-operative inquiry in this study means that the clinicians in the CRHT team are co-researchers. The co-operative inquiry process is practiced by multi-stage focus groups together with the team members, in which two of the researchers of the study (Bengt KARLSSON [BK] and Marit BORG [MB]) are facilitators. Both facilitators have extensive clinical experience in the mental health field as a mental health nurse and an occupational therapist respectively. However they had not worked in this particular service prior to the research implementation and did not know the clinicians in the CRHT team. Focus group meetings are held monthly in order to discuss the processes through which changes are being implemented and to uncover the types of knowledge developed and used in practice by co-researchers. The discussion topics at these focus group meetings have focused upon overall service re-design, team organization and functioning, strengthening collaboration with service users and family members, and general practice development. However, the focus group, in the spirit of co-operative inquiry, has had an active voice in raising topics of particular concern in the development and implementation of new practices. A number of issues have been identified as recurring topics, including the mandate of the team, what being professional involves and means in home treatment contexts, collaboration among team members and the care and safety of patients' children. The focus groups have also examined progress with implementation of

practice developments, service experiences including patient pathways, impact on other services and agencies, and the variety of service-user responses. These meetings were audio taped, transcribed, and summarized for feedback to the team members at subsequent meetings in order for the team to experience "dialogue-based" changes in developing the CRHT team and its practice. [12]

The partnership with the team and their manager started with an open meeting where the objectives of the project were discussed, preliminary ideas shared and the agenda for the focus group work agreed upon. The first focus group meeting was held in January 2008 with the theme of "clinical judgment in crisis situations." The meetings continued once a month until autumn 2010 at the request of the group. [13]

2.3 The processes for developing co-research partnerships

Traditional research is often criticized for being something that is done by people in universities or research institutes for their own interest, for being theoretical rather than practical, and for not really helping people in finding ways to change (FINE, 1994). We support HERON and REASON's view (2008, p.144) that

> "... outcome of good research is not just books and academic papers, but it is also the creative action of people to address matters that are important to them ... it is concerned too with revisioning how we understand our world as well as transforming practice within it." [14]

The two first authors of this paper were the ones involved in the facilitation of the cooperative research process and it is on their (BK and MB) reflections on the facilitation experience that the examples discussed here will be derived. [15]

Before BK and MB started working with the CRHT team they were concerned with their research role. How could they avoid becoming "doing research on" researchers? How could they offer through this work, something meaningful for the team in their process of service transformation and also for the people in crisis situations being supported by this team? BK and MB found that careful reflection about ways of creating an inclusive research process was important, both between the two of them as facilitators as well as in the collaborative research groups. More concretely, they tried to build rapport and develop relationships by attending to and highlighting the various practical and emotional aspects that home treatment involved for the team members, for example in dealing with issues such as demanding encounters with a whole family in crisis, giving priority to helping out with everyday life activities such as tidying or cleaning—although this is really not their job, or simply attending to feelings of not being able to cope with a situation. Through reflections and drawing on previous clinical experiences as well as research experiences in qualitative research and co-operative inquiry, BK and MB emphasized three issues that they thought to be helpful to create congruency between them as facilitators and co-researchers—(a) the use of informal talk, (b) valuing and nurturing everyday life issues and (c) valuing uncertainty (i.e. not defining something as "right" or

"wrong," "true" or "false"). They also emphasized not over-planning for group meetings and being open to "whatever came up" in various situations. [16]

2.3.1 The use of informal talk

Informal talk is a way of helping human beings become at ease, of opening up situations and is simply an everyday way of engagement in social situations. Meetings are often started with some "informal chat" about everyday life experiences, such as our favorite football-team's latest match, events in our lives, conferences or meetings team members just attended, or simply the weather. These informal chats are never tape-recorded. They are in many ways a tool to improve communication and make people comfortable. Sometimes they include humor as group members relay funny or humorous incidents, experiences or observations. Once a famous Danish born comedian Victor BORGE said that laughter is the shortest distance between two people . We find this is also the case in our action research project. Informal talk assists in keeping dialogues open and dwelling on crucial themes. A repeated slogan in the group has been "we are among friends here" as a reminder of we are all in the same boat and as a way of keeping the openness at work. Paying attention to and valuing informal talk demonstrated that no topic was trivial or frivolous as such talk helps to illuminate aspects of the research context. For example, through discussion among group members, the significance of sharing an ice cream with a young male patient whilst sitting on a park bench near his home was identified. The activity was considered important as a means of creating a neutral space for collaborative communication and the building of trust. However, reflections on this example revealed critical questions such as—Is eating ice cream with a patient therapy? Is it something the management at the community mental health center would approve of if they knew? Does this kind of work represent best practice in crisis resolution and home treatment? Facilitated reflection on these questions revealed the significance of the management's approval of team members' daily work as a recurring issue. The research participants were however, also able to identify the humor embedded in this topic and were able to see the funny side of the presumption that therapy is something solely done in a psychologist's or psychiatrist's office in a 45 minute time-slot. [17]

So whilst informal talk acts as a means of creating the focus group ethos as the session commences, it was further hypothesized that the use of such talk as a facilitation strategy in co-operative inquiry enables the equalization of power relationships among co-researchers. [18]

2.3.2 Valuing and nurturing everyday life issues

Another issue the researchers try to nurture is the richness of everyday life and the "little things" of clinical practice. As described in a previous paper (BORG et al., 2010) both the research team and clinical team are inspired by the social network theory named "open dialogue" (OD) developed in Finish Western Lapland in the early 1980s (SEIKKULA et al., 2006), that later inspired service development in many countries. The basic philosophy of OD is providing family-

oriented services for all service users within their individual and social support systems. Keeping the dialogues open for practice knowledge and practice process means openness to differences in concept formation, definition of situations, interpretation of meanings, and approaches to service. The principle of open dialogue in the focus groups was practiced in the discussions as the meetings typically started with a participant offering her or his perspective on a theme that was introduced and the researcher following up by continuously asking for more details. After a while other members became involved in discussions bringing in new ideas and views or just elaborating on the theme. [19]

Focusing on issues that are often dismissed or discounted as "trivialities" enables the emergence of essential knowledge for practice and the demonstrations of competence issues that are critical to service users and their families. However a challenge here is that clinicians themselves often ignore this part of their daily practice and thus it is hard to reach and discover. This has been identified in previous studies (HARDY, MANLEY, TITCHEN & McCORMACK, 2009). [20]

Drawing on OD principles, the researchers/facilitators tried continuously to remind and encourage the focus group members to prioritize reflections over "little things," such as meetings with service users, homes they had visited, and car trips and cafe-meals they had shared with people in mental health distress. The participants often highlighted the extra information they could get when meeting patients in their own home. For example, a team member mentioned that a young man who was referred was described as withdrawn, depressed and potentially suicidal. When they entered his flat they saw ice hockey equipment in the entrance. They immediately thought: he's an ice hockey player—there's more to his life than we've heard about. There were many examples of how team members' home treatment practice revealed a deeper understanding of the person they were trying to help as well as of the practice of crisis resolution and developing knowledge for practice. [21]

Keeping these conversations open has been critical for the research in addressing its research questions. Openness in communication as well as bridging the themes between the meetings was encouraged by facilitation interventions like: "The final issue we talked about last time was home treatment and what that involves and offers, do you remember?" Open dialogue has been a critical strategy in maintaining engagement with the co-researchers and ensuring that it is their interests that are privileged in the focus group discussions. [22]

2.3.3 Valuing uncertainty

The focus groups are facilitated with an emphasis on "in-depth dwelling," i.e. exploring complicated situations from a variety of perspectives. This is achieved by not closing the discussions and by avoiding closures with conclusive or fixed ideas. In the facilitation approach adopted, in contrast to polarizing right or wrong ideas, attempts have been made to explore together the variety of ways of discovering solutions or develop practices through multi-facetted realities.

Meeting people in mental health crisis can be intense, unpredictable and at times rather chaotic. [23]

The team members often dwell on how different this is from working on a ward, where one usually has several colleagues around and where there are routines and procedures to lean from. In a person's home, the professionals are more or less on their own without a collegial network. Exploring "being and doing in the world" around the intense crisis settings at home is both inspiring and challenging for facilitators. It is inspiring to be involved in this innovative and important practice transformation, but it can also feel overwhelming to learn about the variety of challenging situations the team members have to deal with. They describe situations where they leave a patient's home continuing to worry about his or her safety and well-being or situations where a family's despair and distress color their own emotional condition. There are many situations with no simple end or no one single solution. Exploring these strenuous and stressful circumstances together, dealing with agreements and disagreements about solutions, bringing forth various worldviews and perspectives on best practice embodies a context for the generation and sharing of knowledge in collaborative research. [24]

2.3.4 Issues of facilitation

From these experiences, what has been learned about the co-research relationships? One feature of co-research is that of keeping the dialogue open in the focus groups. This involves learning to value uncertainty and a genuine commitment to helping all participants to remain open-minded. Possessing and drawing upon previous clinical experience is helpful in this as well as being open and willing to work with exemplars that the co-researchers present and discuss. It is also helpful to have some knowledge and understanding of the fundamental principles of the open dialogue philosophy. Valuing uncertainty is a central concept in this philosophy and it implies appreciating and listening to what people involved actually have to say. It encourages dwelling on issues, opening oneself up to a variety of perspectives on what is going on and trying to find words for the experiences and activities. The clinical examples raised by the group represent an opening to make and remake stories, identities, and relationships that construct new understandings. Valuing uncertainty also means an acceptance of varying or opposing interpretations as viable ones. Drawing upon the philosophy of open dialogue provides tools for facilitation for research practice as well as for reflection-in-action. [25]

The central issue in the reflections of BK and MB after the meetings were dilemmas related to doing research collaboratively. BK and MB are not convinced that they have succeeded in their efforts at doing research *with*. They sometimes feel that participants view them as researchers that arrive in a meeting room once a month and "do research." As one participant expressed: "I really wonder what you have found out here during these months." Some of the good intentions and well-described practices in participatory action research are demanding and challenging to fulfill in the real world. What BK and MB found however in these collaborative meetings is great inspiration and in-depth learning. They experience

this way of practicing research as meaningful and rewarding in exploring mental health issues and trying to understand the world around them as experienced mental health practitioners. It is important to simply appreciate some of the absence of orderliness in the research process—it makes the research feel "real": Mental health crisis situations are not characterized by orderliness and predictability. The research context mirrors the practice context. It offers "real" context for useful knowledge construction. [26]

3. Discussion

The benefits of participatory engagement by key stakeholders in the research process have been highlighted earlier in this paper. Development of relevant research questions, promoting reliable and relevant research approaches, enhancing dissemination, ensuring the outcomes to be contextualized, and designing usable outputs are all considered to be key benefits derived from stakeholder participation (GUBA & LINCOLN, 1989). [27]

However, facilitating genuine and authentic participation in research is complex and requires researchers to be reflective and reflexive regarding their role as researcher and facilitator of engagement processes. Other researchers and theorists have identified a number of issues that are challenging in achieving this, including the challenge of achieving genuine consensus (GORE, 1992), the limits of inherited dispositions on our freedom to change (FAY, 1987); and the dominance of "cultures of managerialism" (KEMMIS, 2006). These are all critical issues to consider in working with participatory research and have been evident in the work reported here. [28]

The work described in this paper articulates a genuine attempt at being inclusive in a research program and drawing on principles of co-operative inquiry to facilitate this process through the use of informal talk, application of open-dialogue, and valuing uncertainty. However, even with such a clear methodological framework to draw upon, the reality of facilitating meaningful participatory engagement is a challenge and one that researchers need to develop skills in. From our work, we identify four issues that need to be considered in the facilitation of meaningful participation—*consensus, historicity, reflexivity, and knowledge co-production*. [29]

3.1 Consensus

Participatory research methods require a commitment to achieving "consensus" on the part of all participants. However, as it has been illustrated in the example reported in this paper, despite meticulous attention to engagement processes, questions persisted regarding the genuineness of the participation process. GORE (1992) argues that despite best intentions, achieving genuine consensus might be a reified idea because in reality each actor in a social context has multiple agendas and compromise is inevitable. However, the "open dialogue" approach as applied in this research has been found to be helpful in dealing with this issue as the principles of "remaining open" and "valuing uncertainty"

contribute to the creation of a context that leaves room for other perspectives even when it appears that consensus has been reached. [30]

3.2 Historicity

In participatory research, participants assume a role of active negotiators for change and improvement, rather than being passive suppliers of opinion. This reflects a more emancipatory approach to research, where there is a more equal distribution of power between researchers and research participants. However, one reason why consensus is difficult to achieve is that of "historicity" (FAY, 1987). According to FAY (1987) we each (as researchers and research participants) have inherited dispositions that limit our potential to change and "be different." Despite the importance of reflection, some dispositions are too challenging to erase and thus the potential to change not realized. For example, the power of hierarchy in organizations is well documented and the impact of organizational cultures that use hierarchy as a means of power and control "over" others limits the potential of nursing to exercise autonomy in practice. The reflection on the relevance of sharing an ice cream with a client can be considered to represent the challenge of shaking off inherited dispositions of managerialist cultures. A cooperative inquiry method can be seen to enable such issues to be openly discussed and through the sharing of alternative perspectives empower participants to at least be alert to such limitations on their potential to be effective and innovative. [31]

3.3 Reflexivity

The research reported here demonstrates the importance of reflexivity in paying attention to issues of ownership, power, authenticity and meaningfulness in co-operative inquiry. Reflexivity requires the researchers to be aware of themselves as the instrument of research. This is a particularly important issue for action researchers who are intimately involved with the subject of the research, the context in which it takes place, and others who may be stakeholders in that context. Taking account of the way co-researchers relate with each other in the research context is thus critical to a rigorous and ethically sound co-research endeavor. Thus how issues such as those identified in this paper (agenda setting, foci of discussions and management of the agenda) are facilitated has to be different from other qualitative research approaches that do not have equal participation as a value base. NIGHTINGALE and CROMBY (1999) suggest that the researcher needs to be reflexive from two perspectives—personal reflexivity and epistemological reflexivity. [32]

Personal reflexivity involves the researchers reflecting upon how their beliefs, values, experiences, interests, political commitments, wider aims in life, and social identities shape the research. This further involves the researcher reflecting on ways in which the research itself may have changed them as a researcher and as a person. As ARCHER (2000, 2003) suggests, it requires the researcher to engage in "internal reflexive conversations." This is best articulated by TITCHEN, HIGGS and HORSFALL (2007) who suggest that in a co-

researcher relationship, the facilitator choreographs a dance of connections between co-researchers that captures the unique personal experience of each participant whilst at the same time paying attention to action, liberation, illumination, transformation, and ultimately human flourishing. The study reported in this paper illustrates this "dance" of relationships among co-researchers and it also highlights the necessity to be continuously vigilant in paying attention to the agreed processes and using reflection to ensure that espoused values are realized in practice. [33]

Epistemological reflexivity requires the researcher to consider decisions about the research question(s), the chosen methodology, the data collection and analysis methods, and ways in which these create "boundaries" in the research. In an action research context operationalized through cooperative inquiry, reflecting on ownership of research questions, the operationalization of data collection methods, and the processes used for theorizing data are all critical concerns in epistemological reflexivity. In the study reflected upon in this paper, questions of "what matters to co-researchers," "how power is balanced," and "how wide the implications of discussions are" (such as how managers might view the sharing of an ice cream between a service user and a clinician) are key concerns and illustrate the extent to which the facilitator needs to pay attention to detail in the research process. [34]

3.4 Knowledge co-production

The method of co-research presented in this paper provides a platform for what has been described in the literature as "co-production" of knowledge (GIBBONS, 2008). Traditional forms of knowledge production make a distinction between knowledge producers and knowledge consumers and the challenge for any practice-based profession is to find ways of generating, disseminating and using knowledge that inform and are informed by practice itself. PLATO makes a distinction between "those who know and do not act and those who act and do not know." What PLATO is suggesting here is that there are those who strive to know but do not engage in acting on the basis of that knowing and those who act but do not always have the knowledge to underpin their reasoning for acting in a particular way. This argument could be seen to underpin the traditional divide that exists between researchers (those who strive to "know") and practitioners (those who "act"). The hierarchical relationship that exists between the knowledge bearers and the knowledge users is one that has greatly influenced the development of knowledge in health care and indeed has been an inherent barrier to the way that research is perceived among clinicians. McNIFF (1998) suggests that we have grown so accustomed to the idea of the solitary and willful creator that we find it difficult to see the deeper ecology of creation. He argues that we need to look at how things are created and not rely solely on externally derived knowledge and forces to shape our experiences. In order to see what is around us, we need to be able to find systematic and rigorous ways of exploring and making sense of such experiences. One way of doing this is to adopt principles of participatory research with the co-creation of research agendas that focus on the everyday experiences of clinicians and service users and that utilize

systematic processes of inquiry. These participatory and facilitated processes lead to the co-production of knowledge and to a reduction in the reliance on externally derived knowledge to shape and re-shape experiences as the basis for knowledge construction. However, as it has been illustrated in the practice example discussed in this paper, co-producing knowledge is not an automatic process and requires a sustained and committed cooperative relationship, and it requires insightful and reflexive facilitation that pays attention to the processes and ensures incorporation of the shared principles of participation. [35]

Knowledge production through action research such as the one illustrated in this paper is an iterative process in which there is no definitive closure to the process. This is both positive and negative. Knowledge production comes through discussions and reflections of actual practice by actors (research participants) themselves, resulting from new insights and innovations. Participants often apply (experiment) new knowledge in their practice on an on-going basis, making the knowledge to be generative and revisional. While participants in such action research projects are continuously engaged in progressive and revisional knowledge development, the process could deter individual self-critique and evaluation in lieu of the group process. It is the research facilitators who can stimulate the process of knowledge construction and revision, and work to raise discussions of everyday practice to the level of knowledge construction. [36]

4. Conclusion

Developing new ways of working for the enhancement of effectiveness is a key focus in health and social care internationally. Whilst there are a variety of strategies available for service and practice development, it is increasingly accepted that participatory approaches enable a form of engagement that has the potential to transform practice cultures and achieve emancipatory change. However, whilst participatory methodologies (such as action research) have well-established philosophical and theoretical foundations, the complexities of working with these methodologies in practice continue to be challenging for many researchers. Relying on traditional research knowledge and skills only takes us so far in operationalizing participatory approaches. Alongside these skills, researchers need to be able to draw upon a variety of creative and facilitative processes that enable genuine engagement. We can never be sure or take for granted that we achieve genuine engagement, as the unique perspective that each participant brings into the research context creates individual challenges to meaningful engagement. Utilizing strategies that enable a supportive, safe and dynamic milieu to be created is critical to the process. We have articulated some of these based on the experience of facilitating cooperative inquiry with mental health professionals. We also highlight the importance of being reflexive as a key strategy in remaining open to the context of the research and in working with the dynamic relationships that exist in any co-research situation. Ongoing work is needed to articulate the facilitative processes that are most effective in enabling authentic and genuine engagement in cooperative and participative research methodologies. [37]

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Authors

Marit BORG, PhD, BOT, is a Professor in mental health care at the Department of Health Sciences, Buskerud University College, Drammen, Norway, and at Haukeland University Hospital, MoodNet Research Group, Bergen, Norway.

Contact:

Marit Borg

Faculty of Health
Buskerud University College
Grønland 40b
N-3045 Drammen, Norway

Tel: +47-32206400
Fax: +47-32206410

E-mail: marit.borg@hibu.no

Bengt KARLSON, PhD, RN, is a Professor in mental health care at the Department of Health Sciences, Buskerud University College, Drammen, Norway, and at Stavanger University, Stavanger, Norway.

Contact:

Bengt Karlsson

Faculty of Health
Buskerud University College
Grønland 40b
N-3045 Drammen, Norway

Tel: +47-32206400
Fax: +47-32206410

E-mail: bengt.karlsson@hibu.no

Hesook Suzie KIM, PhD, RN, Professor Emerita, College of Nursing, University of Rhode Island, USA; and Project Direct for Research Programs, Institute of Health, Buskerud University College, Drammen, Norway.

Contact:

Hesook Suzie Kim, PhD, RN

Faculty of Health
Buskerud University College
Grønland 40b
N-3045 Drammen, Norway

Tel: +47-32206435
Fax: +47-32206410

E-mail: suzie.kim@hibu.no

Brendan McCORMACK, D.Phil (Oxon.), BSc (Hons.), PGCEA, RNT, RMN, RGN; Professor of Nursing Research, University of Ulster, and at Buskerud University College, Drammen, Norway; Adjunct Professor of Nursing, University of Technology, Sydney; Adjunct Professor of Nursing, Monash University, Melbourne; Honorary Professor, University of Aberdeen.

Contact:

Brendan McCormack

Faculty of Health
Buskerud University College
Grønland 40b
N-3045 Drammen, Norway

Office: +44-2890368187
Fax: +44-2890368202
Mobile: +44-7545420277

E-mail: bg.mccormack@ulster.ac.uk

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