

Ageing and Society

<http://journals.cambridge.org/ASO>

Additional services for *Ageing and Society*:

Email alerts: [Click here](#)

Subscriptions: [Click here](#)

Commercial reprints: [Click here](#)

Terms of use : [Click here](#)



'The Taste Buddies': participation and empowerment in a residential home for older people

VIVIANNE BAUR and TINEKE ABMA

Ageing and Society / Volume 32 / Issue 06 / August 2012, pp 1055 - 1078

DOI: 10.1017/S0144686X11000766, Published online: 26 August 2011

Link to this article: http://journals.cambridge.org/abstract_S0144686X11000766

How to cite this article:

VIVIANNE BAUR and TINEKE ABMA (2012). 'The Taste Buddies': participation and empowerment in a residential home for older people. *Ageing and Society*, 32, pp 1055-1078 doi:10.1017/S0144686X11000766

Request Permissions : [Click here](#)

‘The Taste Buddies’: participation and empowerment in a residential home for older people

VIVIANNE BAUR* and TINEKE ABMA*

ABSTRACT

The active participation and autonomy of older people living in residential homes is considered to be problematic. However, in our action research project conducted in a Dutch residential care organisation we found ways to enhance residents’ direct participation. This form of participation is grounded in deliberative and participatory approaches to democracy. In this article we describe how a group of seven residents (all female), calling themselves ‘The Taste Buddies’, developed a joint vision on how meals could be improved. The facilitation of this process enhanced this group’s empowerment, building interpersonal trust, social identity and joint purpose. We will take the reader through this process and discuss the developments of these older women against the background of relational empowerment. We argue that resident participation as partnership with employees and managers starts with relational empowerment among residents themselves (enclave deliberation). This process is non-linear and requires time and constructive facilitation.

KEY WORDS— participation, older people, relational empowerment, residential homes.

Introduction

When older people move to a residential home their lives can change drastically. In the past they may have been active and lively, and following the move they may lose their vitality, interest and external orientation. There are several challenges for the active involvement and autonomy of older people in residential homes. These challenges are related to the institutionalised environment of long-term care facilities: rigid institutional regime and working routines, structural dependency, depersonalisation, disengagement and frailty that lead to older people feeling they have much less influence on their own quality of life (Abbott, Fisk and Forward 2000; Agich 1993; Baltes and Wahl 1992; Johnson and Barer 1992; Mitchell and Koch 1997;

* VU University Medical Center, Amsterdam, The Netherlands.

Townsend 1981). When daily life in the residential home is governed by the time schedules of staff and the institutional ideas about quality of life (which may differ substantially from the ideas of residents themselves), residents will not feel encouraged to take an active role in working towards practice improvements (Abma *et al.* 2011). Internationally, resident councils and other kinds of resident committees exist in long-term care facilities (Baur, Abma and Widdershoven 2010a; Devitt and Checkoway 1982; Meyer 1991). These formal committees are meant to give residents a say in the policy planning and practice improvements of the organisation and could be seen as a counter-movement to enhance the participation and influence of residents. However, the participation of resident councils is particularly problematic since resident councils are confronted with the dominant power of system over life world (Baur and Abma 2011; Belderok 2002). While resident councils tend to struggle to have any real influence in the organisation, this process might instead even turn out to be disempowering. Resident councils mainly respond to policy documents, often in a late stage when decisions have already been made, and experience trouble in setting their agenda to change processes or services (Baur and Abma 2011; Baur, Abma and Widdershoven 2010a; Meyer 1991). Another problem is related to representation. Older people are very diverse and not all of them are interested in bringing their concerns to the fore. Apathy, scepticism and physical disabilities are the main barriers for older people to participate in resident councils and the agenda of meetings is set by staff and managers (Devitt and Checkoway 1982; Meyer 1991). Hence resident councils lack power in their negotiations with management (Baur, Abma and Widdershoven 2010a; Devitt and Checkoway 1982).

These barriers to resident participation in residential homes are just one side of the story. Insights from political theory, social psychology and evaluation theory present opportunities for the active participation of (older) people in community or research projects. The chances of less powerful groups participating improve when there is room for dialogue with a focus on mutual learning (Baur, Abma and Widdershoven 2010a). Furthermore, creating opportunities for older people to get together with peers with a view to them gaining the confidence to express their views is considered to be very important (Barnes and Bennett 1998). Enclave deliberation (Karpowitz, Raphael and Hammond 2009), group debate (Timoyjjevic and Raats 2006) and collective involvement (Simon 2004) all serve to illustrate the importance of interaction among people within their own group in order to develop a shared vision as a basis for participation and involvement in policy planning or practice improvements. We would like to adopt the notion of enclave deliberation (Karpowitz, Raphael and Hammond 2009) in order to emphasise the importance of the development

of an intimate and political voice of marginalised groups within a 'protected enclave' in which people with the same interests can explore their ideas in an environment of mutual encouragement (Mansbridge 1996; Nierse and Abma 2011). We connect this notion of enclave deliberation to the notion of relational empowerment, which stresses that people can become more autonomous as together they develop a feeling of trust in their own opinion, are able to acknowledge criticism, and appreciate the feasibility of change (Abma, Nierse and Widdershoven 2009; VanderPlaat 1999). This notion of relational empowerment is based on the idea that when power is given from one (powerful) party to another (less powerful) party, or taken from the powerful by the less powerful party, empowerment is imbalanced. Rather empowerment can be seen as a dialogical learning process (Baur, Abma and Widdershoven 2010a). The idea of participatory democracy as an alternative for representative democracy refers to the formation of an informal, temporary vital coalition around a meaningful issue (Barber 2004; In 't Veld 2010). In such coalition interactions are not permanent and regulated by formal procedures and regulations, but rather based on the wish to realise a shared goal. If such a goal is attained and properly anchored within the organisation the coalition may dissolve after some time. In residential settings, the importance of informal contacts and resident groups in enhancing people's quality of life is emphasised to de-institutionalise practices (Reed and Payton 1997).'

This article describes our research project in a Dutch residential home that centred on a group of seven older residents (all female) who became what they called 'The Taste Buddies'. This is the English equivalent of the Dutch '*De Smaakmakers*', an epithet a group of older female residents thought up for themselves. The name alludes to the improvements made to meals, which is what this group stands for. They wanted meals to be more appetising and tasty. More implicitly, the word 'Smaakmaker' also refers to what makes life agreeable and meaningful. And this was exactly what the older women were striving for: more quality in their lives. The word 'taste' can also mean 'experience'. This relates to the fact that these womens' experiences (experiential knowledge) were central to the practice improvements. Further, the relational process that developed among them can be seen as quite a new experience, for themselves, but also for the organisation. They became buddies to each other, and buddies to the managers and staff of the organisation. Finally, the name 'Taste Buddies' is derived from 'taste buds', which emphasises how this group functioned as the taste buds of the residents, by involving the larger community of residents and emphasising that their goal was the common good for all residents.

The purpose of this article is to show that active group participation, relational empowerment, and even co-management of residents, is actually

possible in residential homes. We focus in this article on the importance residents attach to building relationships and positive group dynamics within the 'safe' group of co-residents.

Goals and methodology

Research setting

We were asked by a care organisation for older people in the Netherlands to conduct this research project at one of its residential homes. In the Netherlands, approximately 158,000 older people live in residential and nursing homes (Den Braak 2010). Residential homes as well as nursing homes provide care for older people who cannot live independently anymore due to age or illness. The difference between these forms of care for older people is the intensity of care that is provided. Nursing homes provide intensive and medical care for older people, as well as psycho-geriatric care, whereas residential homes only provide less-intensive forms of care. The location where we conducted our research is a public residential home with in total 129 apartments for people who can still live independently but who need some degree of support. A distinction is made between sheltered accommodation (56 apartments) and residential care apartments (73 apartments). The costs for the residential care are paid by social insurance in the Netherlands. Residents who receive residential care do not pay separately for meals. The residents who live in the sheltered accommodation apartments are self-funding and thus they pay separately for meals. However, the distinction between sheltered accommodation and residential care apartments is hardly visible at this specific location and all residents can have dinner in the joint restaurant. The staff provide cleaning, personal care, and light medical care. This residential care home does not provide care for higher levels of care needs, such as psycho-geriatric care or intensive medical care. Residents can have dinner in the collective dining room, that is called the restaurant. However, they also have a little kitchenette in their apartment where they can prepare simple meals themselves. Nonetheless, most people have dinner in the restaurant (approximately 70 every day).

The management had noticed that this home had not been involved in democratic care innovations since its inception, some 50 years ago. The organisation had many managers come and go in the past decade, which led to a feeling of unrest among staff and residents. We were asked as external researchers from the VU University Medical Center for this project because of our experience with patient participation in chronic care, responsive evaluation and client participation in the care of older people. As researchers we were not familiar with the organisation and its residents prior to

the project. The research project was carried out by the first author, who is a young woman with a degree in cultural studies, and supervised by the second author, who is a middle-aged woman with a degree in nursing and health administration, and 20 years of research experience in the fields of chronic care, psychiatry and elderly care. Our outsider position helped us not to reproduce the more common, sometimes paternalistic interactions with residents. We approached the residents not as clients or patients, but as individuals with a rich background. When we started our project, a new manager had just been appointed. His intention was to improve relations and interaction with and among groups in the home, a move that received a positive reception from staff and residents. A new resident council was also being established, and as the members were busy organising and establishing relations with the manager, they were not interested in participating in our project. We therefore kept the council informed.

The managerial staff of this residential care home consisted of three team leaders for intramural care, extramural care, and general facilities. They had a long track record in the care sector. The employees were also experienced. Many had worked at this place for a long time, and 25–35 years of experience was no exception. Quite a few of the staff longed for the ‘good old days’ when there was time to give residents personal attention. Now they felt overwhelmed by their workload and the bureaucracy. The residents had always had a very sophisticated image since the wealthy middle class of the city used to live there. Stories of exquisite gala dinners, Sunday lunches and an orchestra playing at the home still abound. Now admission to a residential home requires referral on medical grounds, consequently the residents in the home are now more diverse in terms of socio-economic status.

Seven older women with a passion for taste: The Taste Buddies

The seven female residents in the action group for improved meals were over 80 (the youngest was 82, and the oldest 92). They all had a physical disability or illness including diabetes or rheumatism, sight or mobility problems. Four of the participants lived in residential care apartments, the other three lived in the sheltered accommodation. Some were a little shy and circumspect when they first joined the group, but their reservations slowly waned. Others immediately took the lead, like Mrs Janssen (pseudonym) (92) who had been living here for over 16 years. She was careful to express her ideas clearly and politely with regard for the way others perceived her. She encouraged the other group members to voice their ideas and she always inspired the group with her humorous anecdotes. Another important person in the group was Mrs De Vries (82). She encouraged the group to carry on and never give up, and maintained interaction with the other residents. By the

time The Taste Buddies' objective to improve meals had met with success, Mrs De Vries had become the group's standard-bearer, receiving compliments and encouragement from other residents which she cordially shared with the other Taste Buddies.

Action research

The goal of our research project was to enhance the interactive and collective participation of residents in practice improvements and policy issues that affect their daily life in the residential home. This research goal is grounded in a transformative research paradigm in which researchers strive for social justice (Mertens 2009). This paradigm is closely linked to appreciative inquiry as a form of action research (Ludema and Fry 2008). However, there are differences between action research and appreciative inquiry. The main difference is the focus of the researchers. In action research, researchers focus on a particular problem, whereas in appreciative inquiry researchers reject a problem-solving approach. Appreciative inquiry researchers focus on strengths and on what gives life to organisations and systems (Egan and Lancaster 2005; Reed 2007). Both approaches can be placed within the transformative paradigm that becomes manifest in the way the research is conducted, in the social relations among researchers and researched, but also in the research outcomes. Researchers who work within this paradigm use participatory methods with which they explicitly aim to augment the inclusion and equal participation of all groups including those that have been marginalised. Instead of maintaining the more traditional hierarchic object–subject relation, action research strives for joint horizontal collaboration between researchers and participants (Abma, Nierse and Widdershoven 2009; Oliver 1992). The outcomes of such studies focus on enhancing more socially just and democratic social contexts in the practice that is the subject of the research. Our project features action research in which participatory methods are central and in which appreciative inquiry was adopted as a strategy to further the process of empowerment of the participants. Action research is not a single research methodology, but can be considered as a:

family of practices of living inquiry that aims, in a great variety of ways, to link practice and ideas in the service of human flourishing. It is not so much a methodology as an orientation to inquiry that seeks to create participative communities of inquiry in which qualities of engagement, curiosity and question posing are brought to bear on significant practical issues. (Reason and Bradbury 2008: 1)

Since action research is considered to be a family of practices, appreciative inquiry is one of the specific strategies that action researchers can use to serve human flourishing. Appreciative inquiry can be seen as an important

vehicle for change in residential care. In the United Kingdom, for example, the nation-wide My Home Life initiative (see www.myhomelife.org.uk) is underpinned by appreciative inquiry and aims to improve the quality of life for those who live, work and visit care homes through partnerships between researchers, care home practitioners, independent advisors and voluntary groups.

Some researchers promote a combination of action research and appreciative inquiry (Egan and Lancaster 2005) in order to combine the strengths of both approaches and to address some of the weaknesses. The strengths of appreciative inquiry as well as action research relate to the development of a shared sense of new possibilities and ideas for improvement to practice, the enhancement of collaborative action and the development of interpersonal skills (Egan and Lancaster 2005; Reason and Bradbury 2008; Reed 2007). However, weaknesses of action research are distinguished, such as the lack of vision-creation and insufficient attention for the empowerment of participants in the process (Egan and Lancaster 2005). Weaknesses of appreciative inquiry concern the risk of overlooking difficult interpersonal situations and power relations. Furthermore, feelings of anger and frustration may not be voiced within an appreciative inquiry approach and negative aspects of a context may not come forward, which can lead to barriers in the process (Egan and Lancaster 2005; Reed 2007). We argue that by combining action research and appreciative inquiry, a balance can be created in which problems, negative aspects and challenges are being acknowledged without hampering the explicit process of enhancing empowerment and a shared vision for improvements. This way the appreciative focus on the positive and on empowerment will be in balance with acknowledging existing problems and power relations. We made this connection through an emergent design with the action research being responsive to the context and the participants in the setting. We also took an appreciative approach, for example, when the group dynamics started to stagnate in complaints and feelings of powerlessness. We argue that this iterative and developmental process is essential to generating ownership, inclusion and a flourishing human practice. In this context, it is more important to follow an emergent design and be responsive to the participants and the research dynamics than to follow strict methodological steps, as long as the choices that are made can be substantiated. Openness towards participants' issues and creating co-ownership requires the researchers to be flexible in order for the research design to emerge from the issues and experiences of the participants. This approach stems from a social constructionist view of knowledge, a tradition of scholarship that traces the origin of knowledge, meaning, or understanding to human relationships (Gergen and Gergen 2008).

Since the aim of the project was to enhance collective participation, we acknowledged the need to bring a group of residents together, and create a process of empowerment in which relationships among them would become stronger. There has been a shift in social constructionist theory and in care ethics from the individual who is responsible for his own autonomous actions to a concept of human beings as *relational selves* who are socially embedded and whose development requires relations of (inter)dependency with others (Gergen and Gergen 2008; MacKenzie and Stoljar 2000). There is increasing evidence that homogeneous meetings (meetings with people with a converging interest and perspective) are important, particularly for marginalised groups, in order to develop a shared voice as a start for more equal dialogue with other groups (Abma, Nierse and Widdershoven 2009; Barclay 2000; Baur, Abma and Widdershoven 2010a; Karpowitz, Raphael and Hammond 2009). We therefore started with an exploratory dialogue with ten residents, who were selected by asking the staff which residents they thought would be willing to participate in a group conversation about their experiences. We asked them to suggest residents who often participated in social activities, and residents who were less active but might be interested in participating. It is possible that staff could have excluded people who were less articulate or more critical of the home. However, we believe that this did not happen. The people who participated in the group were critical as well as discussing positive experiences. One or two women were initially shy and silent, but became – after some time – more assertive and self-confident.

It became clear from the first dialogue group that meals in this residential home were a very significant practical issue that could be a vehicle for augmenting resident participation when attempting to improve practices in the home. During the first session the group asked if meetings could be held on a regular basis, which we agreed to. They had found the first meeting very worthwhile, and indicated that this homogeneous dialogue gave them a safe place to talk about their life with people in a similar situation. Eight homogeneous meetings were held over a seven-month period. The women gradually formed a cohesive group, as exemplified by the name they gave themselves: The Taste Buddies. The group started to oversee the steps towards improving meals. They became an action group, supported and facilitated by the first author. The group took on responsibility for the process they had set in motion. In addition to the sessions with The Taste Buddies, four additional heterogeneous dialogue meetings were held in which these residents exchanged their experiences and gave advice about meals to the managers and kitchen staff. They also spoke with the other residents during a meeting that was attended by approximately 60 residents. During this meeting it was clear that the ideas of The Taste Buddies corresponded to the ideas of other residents. The wider resident group also

offered support for the practice improvements that were suggested by The Taste Buddies. This article focuses primarily on the homogeneous process that The Taste Buddies experienced.

Research ethics

The residents consented to participate in this research project. They were also involved in the analytical process. This was achieved through checking our interpretations of the data with the participants on a regular basis. Such member checks are considered central to collaborative action research as they help to consensually validate findings, whilst preventing exploitation and hand over some ownership and control to the participants (Holian and Brooks 2004). Additional critical ethical issues arise in the case of collaborative action research (Zeni 1998), particularly when it involves the evaluation of partnerships. Relationships and teamwork are complicated, and a sound evaluation is even more sensitive. We addressed this in our study by creating open, equal and honest relationships, by sharing information, and creating space for every voice to be heard (Holian and Brooks 2004). We engaged in a hermeneutic-dialectical process with The Taste Buddies in reflecting upon the process. For example, we had moments during meetings with The Taste Buddies when we reflected on the dynamics in the group, and with the facilitator (first author) and the supervisor (second author). This was a conscious choice, based on the need to prevent bias. We presented our analysis of the process in a research report, but we first discussed a draft version of this report with The Taste Buddies. We asked them if they recognised themselves and the process they had experienced. Their replies were unanimous: this was indeed what had happened. This research report that was approved of by The Taste Buddies is the basis for this article. With regard to publication, the older women decided that they would like to become co-authors of Dutch-language publications. Involvement in international publications was seen as too labour intensive. All participants (residents, professionals and managers) consented to the use of the data for publications of this action research project.

The results: actions, process and development of empowerment

This section describes the dynamics of empowerment that were generated through this action research project. This process is non-linear in the sense that The Taste Buddies did not exhibit a straight progression from having little influence to feeling empowered. Their development was characterised by an alternating dynamic, comprising of five general phases. In the first

phase, the group of residents – later to become The Taste Buddies – were asked to talk about their experiences of living in the residential home. This provided the means for these residents to set the agenda for the research project and for practice improvements in the home. In the second phase, the residents got to know each other and the researcher (first author). Their interactions were characterised by carefully exploring shared experiences about the meals and initially downplaying anything negative. A turning point led to the third phase when The Taste Buddies began to feel more comfortable with each other. They felt empowered by the discovery that their discontent about meals was mutual. This led to a fourth phase in which the repeated sharing of negative experiences resulted in stagnation. However, a bit of creativity succeeded in bringing this potentially negative spiral to an end. In the fifth phase, the residents succeeded in turning their discontent into constructive advice and partnership with service providers for improving meals. They developed a sense of ownership and responsibility for developing services. This was the point when they started to call themselves The Taste Buddies. We will describe these five phases in more detail below.

Phase 1: Residents set the research agenda

Every client in long-term care institutions in the Netherlands must have a personal file. This new legal requirement worried the manager of the residential care home and the organisation's Board of Directors, so it was recorded as a potential subject for our research project. Although this was an important topic, we informed him that our project really needed to create space, from the outset, for the residents to set the research agenda to enable them to become co-owners of the process. We agreed that if other subjects emerged that mattered more to the residents, we would consult with management.

We started off by having coffee with ten residents. The impression we gained from earlier projects led us to understand that residents might not want to take on too many responsibilities. We deliberately did not use big words, kept our gatherings small, and attendance was not compulsory. We sought to create a welcoming and hospitable atmosphere with coffee and cake. We used the meeting to speak freely about what the participants considered important and meaningful, and about how they experienced daily life in the home. Picture cards of numerous items (art, people, nature, *etc.*) were used to start the conversation. Everyone present, including ourselves, took a card and then told the others why that picture appealed to them. This led to a group discussion about these residents' deeper values and personal identities. They also found recognition with each other. For example, when one person talked about how she had loved to travel when

she was younger, others became enthusiastic and talked about their own travel experiences. During this extensive dialogue about personal experiences, we asked the participants about the extent to which they still found these experiences important in their current life in the home. This question led to the conversation gaining more depth, since most of those present felt that they had had to relinquish many things, people and values when they came to live in the home. Some became emotional. They shared a feeling of loss, and of having to cope with getting old and letting go of the past. They also talked about coping with a feeling of dependency, and about their struggle to hold on to important values. This created a personal atmosphere and even though most of these residents did not know each other, they were comfortable with sharing their personal stories.

Meals turned out to be a very important topic for this group of residents. They emphasised the importance of meals and were cautiously critical about the quality of the food, the way it was prepared, the lack of choice when eating in their own room, the menus, and the lack of a quiet and pleasant atmosphere in the restaurant (ambiance). These issues reflected the importance and meaning of food. Food in residential and nursing homes is not only a matter of nutritional value, but also important to promote social interaction, ambiance and choice (Mathey *et al.* 2001; Nijjs 2006). The residents agreed with each other that dinner time in this home was rather chaotic:

I've not finished my dessert yet, and they want to clean the table already.

It's absolute chaos.

I don't have dinner downstairs [in the restaurant, VB] anymore. It's not pleasant at all.

Moreover, food quality was poor:

It's not fresh. We don't want food that's warmed up.

I don't think we get enough vitamins and minerals in our food.

Their dissatisfaction with the meals was a strain:

It's the only time of the day when you can have a nice get-together. Dinner time means a lot to me.

One person even told us that she had cried a lot when she first came to live in the home because the food was so bad and she realised that she would have to deal with that for the rest of her life because she had no alternative. Another woman illustrated her dissatisfaction with the food by repeatedly saying that she fried an egg and bacon every morning just to make sure she got enough to eat. She did not like the food that was served in the organisation, so she usually only ate the soup and an orange.

Their disappointment about meals was something that they were confronted with every day. One of them emphasised this more than once:

It's a very important part of our lives, it really is!

We noticed during these two meetings that the residents hardly spoke about care-related topics or their personal care files, which the management would have liked us to research. However, we reasoned that a project aimed at enhancing resident participation should start by allowing the residents to set the agenda. We therefore suggested that meals could be the research topic. The residents agreed and were very positive about this proposal. We agreed to continue the group conversations and to focus on meals with a view to developing a shared vision of how meals could be improved.

Fortunately the management of the organisation was positive about this change of topic. We spoke with the local manager and the Board of Directors about the steps we had taken and the residents' desire for improvements to the meals. The managers understood the importance of allowing the residents to set the agenda. They were aware of complaints about the meals, and they were very open to receiving ideas for improvement. The managers saw the resident participation project as a constructive tool for quality improvement. They supported resident participation, even though it meant that criticism about the organisation and the meals would occur.

Phase 2: Exploring shared experiences and downplaying negative ones

Initially most people in the group seemed to play down their complaints and negative opinions about the meals. They said:

The way we got it at home, we'll never get it anywhere else.

Well, tastes differ.

It's so complicated that all tastes differ. Otherwise, the problem would be solved easily.

Feelings of disappointment and feelings of powerlessness were observed, as evidenced by the following quote:

I don't dare complain about it, in that big restaurant . . . No, I can't do that. But I have asked to be able to speak to the cook. Three times already. But I haven't got hold of him yet.

Complaining about food was considered to be unacceptable by the residents. Mrs Janssen stated that she felt bad complaining about the food because it was 'not chic'. She referred to the way she was raised in a respected middle-class family and how she raised her own children. Cultural norms of that time led to people not complaining about food and being grateful for what you

received. These ideas remained with these women. Furthermore, being critical of others or the organisation where they lived was regarded as disrespectful and showing gratitude was felt to be important. The participants had considerable understanding for the difficult economic restrictions imposed on the organisation. Again this reflected the cultural norms that they had been so familiar with throughout their life. However, there were indications that there were negative experiences, and these had to surface for constructive participation.

The turning point: civil disobedience as inspiration

The group dynamics during the meetings with the older women changed gradually. After the first two or three meetings, the atmosphere became more intimate and the residents felt supported by each other and by the facilitator. One particular turning point in the development of the group dynamics was when Mrs Janssen told the others how she had protested about the quality of the meal that she had received:

This week we got fried rice, so dry, so dry . . . and I was given a piece of meat with it. Well, to be honest, it was inedible, inedible. Then I called someone from the staff. I've been living here for 16 years now, and I've never said this . . . But I said: I am not going to pay for this food.

After dinner, the receptionist told Mrs Janssen that she had deleted her dinner bill. But Mrs Janssen was not satisfied. She said to the receptionist:

No, it's not about deleting the bill. You should tell the manager that there are ladies here who do not want to pay for their meals. That's what you should do. Not simply delete the bill! I really got myself all worked up about it!

This was not about paying for meals. What mattered was Mrs Janssen's message:

It's about them feeling it for once!

Mrs Janssen's articulate story resulted in a new group dynamic. Others were touched by her courage and civil disobedience and it inspired them to protest when they were not happy with their meals:

I'm going to do that as well, really! I didn't know that it was possible, but I'll do it as well!

This striking example of civil disobedience helped the residents understand that they had choices other than to accept passively what was provided by the organisation. Factually speaking, this may not be called civil disobedience since Mrs Janssen made a valid complaint. However, we describe it like this, because the other women experienced this account as an example of civil disobedience. They were so used to being passive and not complaining,

therefore declaring their opinion was an eye-opener for them. They realised that they could join forces and influence what bothered them. A process of relational empowerment started to develop. Mrs Janssen lived in the sheltered accommodation and received a separate bill for meals every month. Therefore, she was in a position where she could threaten not to pay for the meals. It could be argued that this gave her more power than other residents, who lived in the residential care apartments and received meals that were paid by the social insurance. However, Mrs Janssen did not have an alternative option. She could no longer prepare meals for herself. Therefore, the sense of control that residents may have had in this context as consumers who pay for care and services was very limited.

Phase 3: Visible empowerment

This example of civil disobedience stirred this group. Those who had initially been a little quiet and cautious now gained confidence. They believed that they could also say what was on their minds:

I'm glad I now hear that there are more people who think like this about the meals. I didn't dare say anything before. Honestly, I didn't dare: I thought it was just me. But what you did, protesting against it, that's what I'm going to do as well.

I've put out my feelers to find out if other residents also want change.

After all, we're here by ourselves, we can speak freely about it.

The women felt supported by each other. The group conversations were now based on trust: they trusted each other more because they had got to know each other. Trust in their own opinions strengthened. Initially they had had doubts about whether or not they could actually make a worthwhile contribution to improving services, but now they felt more confident that their experiences did matter. They also realised that what they had in common was their negative experiences with the meals, whereas they initially thought that their ideas about meals were unique to them. For the first time they understood that what they had considered to be an individual matter was actually a problem that they shared with others. The personal became political, and this awareness sowed the seeds for group empowerment (White 2008). Their mutual support led them to believe that they could bring about change. There was a growing feeling of urgency and these residents became more assertive.

Instead of accepting the situation and trivialising their complaints as they did in the initial meetings, the residents started to talk constructively about how to improve the meals. They developed an activist attitude:

I don't ask for a three-course dinner, that's not what I need. But simply fresh food, that's all!

I'm not a glutton, I only want food that has a bit of taste.

I don't want to be proved right, I want something to be done about it.

These individuals who subordinated their negative experiences to the interest of the organisation – it is impossible to make things right for everybody because tastes differ – now repeatedly encouraged each other to stay positive and strong:

We're not asking for perfection, just for improvement!

An active and constructive attitude replaced fatalism. Instead of excusing the organisation for the quality of the meals, the older women started to call the organisation to account and accept responsibility for delivering good quality meals.

Phase 4: Stagnating process

Along with the residents' growing confidence and assertiveness, we observed that they tended to reiterate their grievances, over and over again. After three meetings the group dynamics started to stagnate. This was not productive for enhancing participation, since they were stuck in a circle of complaints and lack of belief that the organisation would do something about their complaints. However, we wanted to follow an appreciative approach, as a focus on the vitality in the group and explore 'what gives life to human systems when they function at their best' (Ludema and Fry 2008: 282). We therefore proposed that the women made a paste-up of what they thought the meals should look and taste like in their dreams. We asked the group to think about a situation in which anything is possible and their wishes were fundamental to this. Creative methods can be very effective for breaking through negative patterns and accessing and expressing dreams and intuitions, and can lead to a learning process (Mackewn 2008; Mullett 2008). The women felt positively about this creative activity and it halted the downward spiral since they had to envision an ideal situation in which anything was possible. Instead of explaining about what was wrong with the meals, they now talked about tasty, good quality meals, served in a pleasant, sympathetic atmosphere. Stories of the past were retold and relived, such as the dinner galas that used to be organised in this care home. Recipes were exchanged. They recalled and told each other about how they had been good cooks for their families. This reinforced the group dynamics and positive relations among the women. Moreover, it increased their feeling of resilience. Energy was flowing through the group again, leading to a feeling of trust. The group had learned how to transform their discontent into constructive advice for practice improvement.

Phase 5: Ownership and responsibility

The growing empowerment and trust also created a feeling of ownership. Ownership pertains to a high degree of participation which leads to a feeling that one has co-produced the outcome (Dunston *et al.* 2009). These residents became co-managers, in the sense that they had real influence. They were proud of themselves. This was expressed by some of these residents. They even thought up a name for themselves to emphasise their group identity: The Taste Buddies. They felt that they owned the practice improvements:

If the other residents say that the meals have improved a bit, I think: ha, that's what we achieved!

We can pat ourselves on the back. Look what we've managed to get done.

Even though the residents developed a sense of pride and ownership, they remained modest. These residents did not want to put themselves in the limelight, and they regularly emphasised this:

We're not doing this for ourselves. We're doing it for the other residents as well.

This remark also demonstrates that these residents set themselves the task of contributing to the quality of the meals that other residents could enjoy. These residents, who were initially very careful when expressing their opinions, now considered it their responsibility to stand up for the other residents. They also decided that it was their responsibility to confront the organisation about the meals:

It has to be voiced. After all, they [the organisation] should know where they stand.

The continuation

The Taste Buddies process resulted in tangible practice improvements in the meals in this particular home. Residents who preferred to have dinner in their own room can now choose from a menu, instead of being 'surprised' every day by what they were given to eat; the location now has its own kitchen and two cooks, with fresh food being prepared on site so that it retains quality and temperature; care workers now wait outside the restaurant to pick people up instead of urging them to finish their dinner quickly; there is now direct communication between residents and cooks by the cooks walking through the restaurant and chatting with residents; and the monthly theme dinners have been reinstated. Through dialogue with other stakeholders (other residents, managers and staff), this group developed a partnership relationship with those responsible for making changes in the organisation. Through the dialogue meetings with The Taste Buddies, managers and staff

learned that they have a common interest, namely the well-being of residents and the delivery of good high-quality services. Even though some of the advice of The Taste Buddies were quite a (financial and logistical) challenge for the organisation – especially the wish of the residents for the care home to have its own kitchen again where fresh meals would be prepared – the managers and staff saw the opportunity to improve their practice for the common good of the residents and the organisation. After the research project had finished and the group meetings with The Taste Buddies were facilitated by the manager responsible for the meals, two representatives from The Taste Buddies were involved in interviewing applicants for the job of new cook. This was not a tokenistic involvement: at first, the residents' and the managers' opinions about who should be appointed differed. The managers took the observations of the residents seriously and asked the applicants to come back for second interview. Finally, after balanced deliberation between these residents and the managers about the pros and cons of the applicants, the cook who was the residents' choice was given the job. The Taste Buddies are still actively involved in improving the meals. Together with the managers, cook and staff, they deliberate on new concepts for serving meals. They have a say in the menu and are asked to think about special theme dinners that are organised monthly, because this was one of the original ideas of The Taste Buddies. Relationships between The Taste Buddies, managers and staff have changed. They now have a partnership.

Discussion and conclusion

These older women, who cautiously explored the group dynamics and what they could say to each other, developed a sense of pride, trust, responsibility and ownership. This was the foundation for an empowerment process, which was not a linear event, but a fluctuating process. What we see here says something about the value of group meetings for these residents. This was particularly the case in a context that is characterised by unequal power relations and with groups that feel marginalised or without real influence. Having opportunities to exchange experiences through sharing stories within one's 'own' safe group were important to these individuals (Baur, Abma and Widdershoven 2010a; Karpowitz, Raphael and Hammond 2009; Nierse and Abma 2011; Ryfe 2006). It is crucial that people seeking either personal or community change have the support of a collectivity that provides a new communal narrative around which they can sustain change (Rappaport 1995). In this way, less powerful groups can coalesce by discovering their common interests and identities, and strengthen their capacity to advocate for themselves (Goodin and Dryzek 2006; Nierse and

Abma 2011; White 2008). This is when empowerment occurs, on the level of individuals, organisations and communities (Zimmerman 2000). Therefore, deliberative democracy, participation and empowerment are concepts that closely and mutually influence one another: democracy and participation foster empowerment, and vice versa.

The question arises however, how collective forms of participation, like the actions of the Taste Buddies, can become more widespread in residential and nursing home care for older people and in a context where an increased proportion of older people have a degree of cognitive impairment, such as dementia (Ferri *et al.* 2005). Cognitive impairment may challenge opportunities for deliberative democratic participation of older people in institutional care settings. However, we argue that cognitive impairment does not prohibit participation. Policy makers and managers in institutional care for older people can learn from the experiences of researchers who work with people with dementia. Frail older people with dementia are being meaningfully involved in qualitative research (Barnes and Bennett 1998; Hubbard, Downs and Tester 2003; Mitchell and Koch 1997). People with dementia still have a sense of self, personality, thoughts, feelings and a voice (literally and figuratively speaking). In order to involve people with dementia in research, special strategies are recommended (*e.g.* greater flexibility and time, and discussions with formal and informal carers) (Hubbard, Downs and Tester 2003). Individual participation of people with dementia through their narratives (interviews) and the inclusion of significant others support the voice and influence of this specific group of older people in research and policy making. However, further research is needed on the extent to which older people with cognitive impairment can participate *collectively* in practice improvements in the institutional care context, in a way that is comparable to the process of The Taste Buddies. Insights about the possibilities for influence and participation of people with dementia in nursing homes will prevent their valuable experiences and perspectives being denied legitimacy.

Various organisational and structural factors can be identified that enabled this project to succeed and which may be limiting factors in other contexts. One critical factor is the support for the participation of residents among the managers in this organisation. The Board of Trustees and the Board of Directors were important protagonists of the whole project. The local manager of the residential care home also supported the idea of involving residents in decision making and acted as a role model for his employees. He, for example, introduced the idea of having lunch with the residents once a week. Both managers were open to new ideas and willing to create the conditions needed to implement the changes identified by the residents. At the time of the project there were enough resources in this

organisation for new ideas and innovations. Financial resources could, for instance, be found to re-open the local kitchen. This success motivated the residents to continue with their involvement. Currently, in The Netherlands the financial situation of many care organisations is less rosy and much tighter, and this makes it harder to set up new initiatives and to motivate and implement residents' ideas. Residents and employees feel upset and disempowered by the enormous cost-cuttings which reduce possibilities for social support. In this situation it is much harder for all parties to stay motivated to keep on investing time and energy in quality improvements.

Our project with The Taste Buddies emphasises the importance of creating time and space for the exchange of experiences through narratives within one's own group in order to heighten a sense of empowerment. This does not occur automatically, it requires facilitation, therefore the role of the researcher is a subject for further discussion. Many have acknowledged the strong role that facilitators/researchers/evaluators engaged in social change actually play (*e.g.* Mertens 2009; Reason and Bradbury 2008; Ryan and Schwandt 2002; Ryfe 2006). We use the concept of relational empowerment here to address the facilitator's role. VanderPlaat (1999) views relational empowerment as a mutual process in which all who are involved, change. This is based on the idea that power is not given or taken but emerges through interaction with others. Facilitators of social change have to use their skills by holding them up against the realities of other people's lives and experiences. If this is not the case, facilitators will only maintain unequal power balances. Therefore this relational approach requires the facilitator to become part of the empowering process. Facilitators must acknowledge where their own power *and* disempowerment rests. This project with The Taste Buddies informed the fluctuations in their empowerment process, and this was also reflected in the role of the facilitator. When The Taste Buddies were shy and circumspect, the facilitator (first author) adopted a supportive role by encouraging the older women to speak up and share their experiences. When The Taste Buddies became more assertive, the facilitator could be less actively supportive leaving space for the group dynamics to develop. The facilitator felt empowered by The Taste Buddies when these residents felt powerful. When the group dynamics seemed to descend into a negative spiral (complaining about feeling incapable of changing the status quo), the facilitator intervened more actively by offering creative tools and stimulating The Taste Buddies to see their potential to change the situation. These sometimes paradoxical polarities and mechanisms of relational empowerment in the facilitator's role should be acknowledged and embraced (Mackewn 2008; VanderPlaat 1999).

Facilitation of action research that is combined with appreciative inquiry can be considered as acting *in the moment*: the facilitator continually asks

herself, and sometimes the group, what is needed at that particular moment. Mackewn (2008) emphasises that this requires facilitators to be aware of their own energy and the group's energy by paying attention to the atmosphere in the room, and observing the body language of those involved. In our project, during these changing dynamics, not only the form and intensity of the facilitation changed, but also a dynamic of feeling empowered and disempowered occurred in the facilitator herself. This particularly occurred when The Taste Buddies started to repeat the same issues and felt negative about any real opportunity for change, the facilitator was confronted with her own sense of disempowerment in this process. However, instead of concluding that the project would not lead to anything, the relationship between the facilitator and The Taste Buddies turned out to be one of the driving forces (as well as the desire for improved meals, social change and a successful research project) behind everyone trying to make the best of it. The facilitator felt supported by her supervisor (second author), who not only acted as a supervisor, but also as a sparring partner and motivator. She listened to the facilitator's doubts and fears and helped her turn them around by showing her a different perspective ('Stagnation is obviously also part of the process of resident participation. It is not a simple, linear process and this adds new insights to ideas about participation. Just go on with it and see where it can lead you') and by giving suggestions. The second author, in turn, felt supported by the organisation's Board of Directors by their unequivocal drive to make resident participation possible. Afterwards, The Taste Buddies repeatedly told the facilitator that success would not have been possible without her facilitating efforts. She always replied that this was all down to the joint inspiration of The Taste Buddies themselves. Finally, they concluded together that it was the relational process among all of them that created the catalyst for change. When the project came to an end, relationships between the (former) facilitator and this group of older women continued, and friendships have developed. Clearly, there is no evidence in this project for the traditionally distant and supposedly objective stance of the researcher. However, we argue that without this relational approach to empowerment, no structural changes in traditionally unequal power relations (between researcher/facilitator/observer and 'research objects') will occur.

The same relational approach applies to the relationships among the various groups in the residential care home (residents, employees, managers): the empowerment of The Taste Buddies could not have come about without empowering relationships having been built with other groups that, traditionally, are in a more powerful position. This also ensures that group think and polarisation is avoided, a joint action agenda and support for practice improvements is created, and that this form of 'enclave

deliberation' is compatible with the normative basis for deliberative democracy by exposure to the public at large (Baur *et al.* 2010*b*; Karpowitz, Raphael and Hammond 2009). This process will be described elsewhere. Here we argue that the relational empowerment process among residents, employees and managers would probably not have been possible without there first being empowerment of The Taste Buddies in their own group. To begin with they had to build interpersonal trust, to find common ground and a communal narrative, to develop a social identity, and to explore their ideas and experiences in an environment of mutual encouragement (Karpowitz, Raphael and Hammond 2009; Rappaport 1995; Zimmerman 2000). This led to a relational process which enhanced their joint empowerment and which they used to participate in practice improvements.

The Taste Buddies showed that – despite their physical impairments and old age which are generally seen as obstacles to participation (*e.g.* Johnson and Barer 1992; Meyer 1991) – residents in residential care homes can play an important role in influencing and shaping their environment. One of the ways in which this can succeed is by facilitating relational empowerment both as a process and as an outcome. Through this, seven older women became The Taste Buddies, who had a strong social identity and purpose, and they made practice improvements in the meals both visible and tangible. Together they enact the dream of Simone de Beauvoir (cited in Moody 2006: 119): 'One's life has value so long as one attributes value to the life of others, by means of love, friendship, indignation and compassion'.

Acknowledgements

In the very first place we would like to thank The Taste Buddies for their enthusiastic participation in our action research and for their humour, perseverance, and optimism. We also acknowledge the managers and staff from this residential care home for their openness and willingness to share their experiences with us and, moreover, for their readiness to see residents as equal partners in practice improvements.

References

- Abbott, S., Fisk, M. and Forward, L. 2000. Social and democratic participation in residential settings for older people: realities and aspirations. *Ageing & Society*, **20**, 327–40.
- Abma, T. A., Bruijn, A., Kardol, T., Schols, J. and Widdershoven, G. A. M. 2011. Responsibilities in elderly care. The narrative of duty and relations of Mr Powell. *Bioethics*. doi:10.1111/j.1467-8519.2011.01898.x.
- Abma, T. A., Nierse, C. J. and Widdershoven, G. A. M. 2009. Patients as partners in responsive research: methodological notions for collaborations in mixed research teams. *Qualitative Health Research*, **19**, 3, 401–15.

- Agich, G.J. 1993. *Autonomy and Long-term Care*. Oxford University Press, Oxford.
- Baltes, M. and Wahl, H.-W. 1992. The behavior system of dependency in the elderly: interaction with the social environment. In Ory, M., Abeles, R. and Lipman, P. (eds), *Aging, Health and Behavior*. Sage Publications, Newbury Park, California, 83–105.
- Barber, B.R. 2004. *Strong Democracy. Participatory Politics for a New Age*. Berkeley, California: University of California Press.
- Barclay, L. 2000. Autonomy and the social self. In Mackenzie, C. and Stoljar, N. (eds), *Relational Autonomy. Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford University Press, Oxford, 52–71.
- Barnes, M. and Bennett, G. 1998. Frail bodies, courageous voices: older people influencing community care. *Health and Social Care in the Community*, **6**, 2, 102–11.
- Baur, V.E. and Abma, T.A. Resident councils between life world and system: is there room for communicative action? *Journal of Aging Studies*, in press, doi:10.1016/j.jaging.2011.03.001.
- Baur, V.E., Abma, T.A. and Widdershoven, G.A.M. 2010a. Participation of marginalized groups in evaluation: mission impossible? *Evaluation and Program Planning*, **33**, 3, 238–45.
- Baur, V.E., Van Elteren, A.H.G., Nierse, C.J. and Abma, T.A. 2010b. Dealing with distrust and power dynamics: asymmetric relations among stakeholders in responsive evaluation. *Evaluation*, **16**, 3, 233–48.
- Belderok, J.J. 2002. *Zorg voor zelfstandigheid. Bewonersparticipatie in verzorgingshuis en verpleeghuis in het licht van drie moderniseringstheorieën [Care for Independence. Resident Participation in Residential Care Home and Nursing Home in the Light of Three Theories of Modernity]*. SWP, Amsterdam.
- Den Braak, M. 2010. *Oudere thuisbewoners. Landelijk overzicht van de leefsituatie van ouderen in instellingen 2008/2009 [Older People Living in Care Homes. National Overview of the Living Situation of Older People Living in Institutions 2008/2009]*. Sociaal en Cultureel Planbureau, Den Haag.
- Devitt, M. and Checkoway, B. 1982. Participation in nursing home resident councils: promise and practice. *The Gerontologist*, **22**, 1, 49–54.
- Dunston, R., Lee, A., Boud, D., Brodie, P. and Chiarella, M. 2009. Co-production and health system reform – from re-imagining to re-making. *The Australian Journal of Public Administration*, **68**, 1, 39–52.
- Egan, M. and Lancaster, C.M. 2005. Comparing appreciative inquiry to action research: OD practitioner perspectives. *Organization Development Journal*, **23**, 2, 29–50.
- Ferri, C.P., Prince, M., Brayne, C., Brodaty, H., Fratiglioni, L., Ganguli, M., Hall, K., Hasegawa, K., Hendrie, H., Huang, Y., Jorm, A., Mathers, C., Menezes, P.R., Rimmer, E. and Sczufca, M. 2005. Global prevalence of dementia: a Delphi consensus study. *The Lancet*, **366**, 2112–7.
- Gergen, K.J. and Gergen, M.M. 2008. Social construction and research as action. In Reason, P. and Bradbury, H. (eds), *The Sage Handbook of Action Research. Participative Inquiry and Practice*. Sage Publications, Los Angeles, 159–171.
- Goodin, R.E. and Dryzek, J.S. 2006. Deliberative impacts: the macro-political uptake of mini-publics. *Politics & Society*, **34**, 2, 219–44.
- Holian, R. and Brooks, R. 2004. The Australian National Statement on ethical conduct in research: application and implementation for ‘insider’ applied research in business. *Action Research International*, paper 7. Available on-line: <http://www.scu.edu.au/schools/gcm/ar/ari/p-rholiano4.html>

- Hubbard, G., Downs, M. G. and Tester, S. 2003. Including older people with dementia in research: challenges and strategies. *Aging & Mental Health*, **7**, 5, 351–62.
- In 't Veld, R. 2010. *Knowledge Democracy. Consequences for Science, Politics, and Media*. Springer, Dordrecht, The Netherlands.
- Johnson, C. L. and Barer, B. M. 1992. Patterns of engagement and disengagement among the oldest old. *Journal of Aging Studies*, **6**, 4, 351–64.
- Karpowitz, C. F., Raphael, C. and Hammond, A. S. 2009. Deliberative democracy and inequality: two cheers for enclave deliberation among the disempowered. *Politics and Society*, **37**, 4, 576–615.
- Ludema, J. D. and Fry, R. E. 2008. The practice of appreciative inquiry. In Reason, P. and Bradbury, H. (eds), *The Sage Handbook of Action Research. Participative Inquiry and Practice*. Sage Publications, Los Angeles, 280–97.
- MacKenzie, C. and Stoljar, N. (eds) 2000. *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self*. Oxford University Press, Oxford.
- Mackewn, J. 2008. Facilitation as action research in the moment. In Reason, P. and Bradbury, H. (eds), *The Sage Handbook of Action Research. Participative Inquiry and Practice*. Sage Publications, Los Angeles, 615–29.
- Mansbridge, J. J. 1996. Using power/fighting power: the polity. In Benhabib, S. (ed.), *Democracy and Difference: Contesting Boundaries of the Political*. Princeton University Press, Princeton, New Jersey, 46–67.
- Mathey, M. F., Vanneste, V. G., de Graaf, C., de Groot, L. C. and Van Staveren, W. A. 2001. Health effect of improved meal ambiance in a Dutch nursing home: a 1-year intervention study. *Preventive Medicine*, **32**, 416–23.
- Mertens, D. 2009. *Transformative Research and Evaluation*. Guilford Press, New York.
- Meyer, M. H. 1991. Assuring quality of care: nursing home resident councils. *The Journal of Applied Gerontology*, **10**, 1, 103–16.
- Mitchell, P. and Koch, T. 1997. An attempt to give nursing home residents a voice in the quality improvement process: the challenge of frailty. *Journal of Clinical Nursing*, **6**, 453–61.
- Moody, H. R. 2006. *Aging: Concepts and Controversies*. Sage Publications, Thousand Oaks, California.
- Mullett, J. 2008. Presentational knowing: bridging experience and expression with art, poetry and song. In Reason, P. and Bradbury, H. (eds), *The Sage Handbook of Action Research. Participative Inquiry and Practice*. Sage Publications, Los Angeles, 450–63.
- Nierse, C. J. and Abma, T. A. 2011. Developing voice and empowerment: the first step towards a broad consultation in research agenda setting. *Journal of Intellectual Disability Research*, **55**, 4, 411–421.
- Nijs, K. 2006. Optimizing the ambiance during mealtime in Dutch nursing homes. Thesis, Wageningen University, The Netherlands.
- Oliver, M. 1992. Changing the social relations of research production. *Disability, Handicap & Society*, **7**, 2, 101–15.
- Rappaport, J. 1995. Empowerment meets narrative: listening to stories and creating settings. *American Journal of Community Psychology*, **23**, 5, 795–808.
- Reason, P. and Bradbury, H. (eds) 2008. *The Sage Handbook of Action Research. Participative Inquiry and Practice*. Sage Publications, Los Angeles.
- Reed, J. 2007. *Appreciative Inquiry. Research for Change*. Sage Publications, Thousand Oaks, California.
- Reed, J. and Payton, V. R. 1997. Understanding the dynamics of life in care homes for older people: implications for de-institutionalizing practice. *Health and Social Care in the Community*, **5**, 4, 261–8.

- Ryan, K. E. and Schwandt, T. A. 2002. *Exploring Evaluator Role and Identity*. Information Age Publishing, Greenwich, CT.
- Ryfe, D. M. 2006. Narrative and deliberation in small group forums. *Journal of Applied Communication Research*, **34**, 1, 72–93.
- Simon, B. 2004. *Identity in Modern Society: A Social Psychological Perspective*. Blackwell Publishing, Malden, Massachusetts.
- Timoyjjevic, L. and Raats, M. M. 2006. Evaluation of two methods of deliberative participation of older people in food-policy development. *Health Policy*, **82**, 302–19.
- Townsend, P. 1981. The structured dependency of the elderly: a creation of social policy in the twentieth century. *Ageing & Society*, **1**, 5–28.
- VanderPlaat, M. 1999. Locating the feminist scholar: relational empowerment and social activism. *Qualitative Health Research*, **9**, 6, 773–85.
- White, H. C. 2008. *Identity and Control. How Social Formations Emerge*. Second edition, Princeton University Press, Princeton, New Jersey.
- Zeni, J. 1998. Guide to ethical issues and action research. *Educational Action Research*, **6**, 1, 9–19.
- Zimmerman, M. A. 2000. Empowerment theory. Psychological, organizational and community levels of analysis. In Rappaport, J. and Seidman, E. (eds), *Handbook of Community Psychology*. Kluwer Academic/Plenum Publishers, New York, 43–64.

Accepted 20 July 2011; first published online 26 August 2011

Address for correspondence:

Vivianne Baur, Department of Medical Humanities,
VU Medical Centre, Van der Boechorststraat 7,
Amsterdam 1081 BT, The Netherlands.

E-mail: v.baur@vumc.nl