



# Dealing with Distrust and Power Dynamics: Asymmetric Relations among Stakeholders in Responsive Evaluation

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## Abstract

Asymmetric relations among stakeholders create challenges in participatory evaluation processes. Power and conflict may hinder equal and genuine communication about the value of the practices evaluated. Guidelines to deal with these sociopolitical challenges are scarce and usually focus on the need for evaluators to remain distant or to handle resistance. In this article we discuss the use of a specific interpretation of responsive evaluation as an approach to foster dialogues among stakeholders in politically laden contexts. We aim to illustrate how asymmetric relations can be dealt with constructively, focusing on inclusion of marginalized groups, mutual learning and good dialogue. Two reflective case narratives are presented of responsive evaluation projects in settings with marginalized groups (client councils in elderly care and psychiatric clients with severe drug abuse). We reflect on the role of the evaluator in these contexts and discuss the justification for the active engagement of evaluators to enhance practice improvements.

## Keywords

dialogue, asymmetric relations, inclusion, marginalized groups, mutual learning, responsive evaluation

## Introduction

This article examines how responsive evaluation can address challenges involving asymmetric relations among stakeholders. The aim of responsive evaluation, originally rooted in the work of Robert Stake (1975) and further developed by others (Abma and Widdershoven, 2005; Greene and Abma, 2001; Guba and Lincoln, 1989), is to include the issues of as many stakeholder groups as

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possible in the evaluation by engaging them in evaluative interaction (Abma, 2005; Greene and Abma, 2001; Guba and Lincoln, 1989; Koch, 1994; Stake, 1975, 1980).

However, involving multiple stakeholders in the evaluation process raises questions about the cooperation and participation of stakeholder groups in vulnerable situations, and about their willingness to collaborate with other stakeholders in the evaluation process. Vulnerable groups in particular might feel they are being judged or they might not trust other stakeholders or the evaluator. They may develop strong defence mechanisms, or withdraw and remain silent during the evaluation process (Koch, 2000; McDonald, 2008; Mertens et al., 1994). This implies that their participation and collaboration in the evaluation process will not surface naturally which therefore impedes responsiveness. This is of particular importance for responsive evaluation, since it regards social relations among stakeholders not as irrelevant or as sources of error, but as intrinsically valuable for the evaluation process (Abma and Widdershoven, 2008). In addition, if the relationships among stakeholders are characterized by asymmetries, power differences and conflict, evaluators can find themselves confronted with the challenge and obligation to attend to the quality of the relations.

Asymmetric relations in evaluation raise questions about the role and responsibilities of the evaluator in the evaluation process. The evaluator in responsive evaluation can be seen as an interpreter, educator, Socratic guide and facilitator who engages in the process of establishing the conditions for dialogue among stakeholders (Abma et al., 2001). Responsive evaluators are never distant. On the contrary: 'a certain intimacy, prolonged collaboration, and personal engagement are required to illuminate the perspectives of others' (Abma et al., 2009). When evaluators are involved in establishing more symmetric power relations among stakeholders, their involvement and value commitment requires reflection and justification (Abma and Widdershoven, 2008; Schwandt, 1997; Wadsworth, 2001).

In this article we use two case studies, conducted in a residential elderly care setting and in a psychiatric hospital respectively, in order to illustrate the changing, active roles of responsive evaluators. The elderly care project is a case study in which, during the evaluation process, several prejudices, distrust and power differences among the stakeholders had to be dealt with in order to establish a genuine dialogue between those involved. The second project in a psychiatric setting can be characterized as a situation in which there was considerable interdependency and asymmetry among professionals e.g. nurses and psychiatrists, and among professionals and stigmatized clients. A controversy developed over the new coercive treatment for clients admitted for severe drug abuse. This particular treatment could easily lead to conflict and censure from society at large.

Both evaluation settings shed light on how to go about making social relations among stakeholders and between stakeholders and the evaluator 'the point' in evaluation, and how to exploit these relations constructively in order to establish practice improvements. We illuminate these dynamics by reflecting on several dimensions of the projects. We first consider the issue of building trust, and focus specifically on the inclusion of marginalized groups. We then reflect on the issue of how asymmetry and power imbalances can be used constructively in responsive evaluation by establishing dialogue and mutual learning processes among all concerned.

## Methodology

The roots of responsive evaluation lie in the 1970s. Calling for a wider scope for evaluation than mere goal-oriented evaluation, Stake (1975) introduced a responsive approach as part of his vision for educational research and evaluation. Central to this vision is the broadening of evaluation

criteria to as many stakeholder issues as possible, unlike evaluation models which merely include the goals and intentions of policy-makers. Responsive evaluation includes processes, backgrounds and judgements, rather than the focus being simply on measuring outcomes (Abma and Stake, 2001; Greene and Abma, 2001; Koch, 1994; Stake, 1975, 2004). Stake's original ideas have been further developed by others. Guba and Lincoln (1989), for example, built on Stake's work, proposing an interactive approach in which stakeholder issues are a starting point for negotiation to enhance mutual understanding and consensus. In our project we used a particular interpretation of responsive evaluation, linking the responsive evaluation paradigm (Guba and Lincoln, 1989; Stake, 1975) to insights into the inclusion of marginalized or vulnerable stakeholder groups, narratives, storytelling and ongoing dialogues in evaluation (Abma, 2003; Abma and Widdershoven, 2005, 2006; Widdershoven, 2001). The latter approach uses hermeneutic dialogue to engage stakeholders in a learning process to help them better understand themselves and each other, and hence put their own viewpoints into perspective. In this way stakeholders gain a better understanding of a given practice through the combination and amalgamation of various different perspectives. Stakeholders in the original responsive evaluation approaches (Guba and Lincoln, 1989; Stake, 1975) are information-givers instead of partners in the evaluation. In the adapted version of responsive evaluation, responsive evaluators build partnership relations with stakeholders, so that they become co-owners of the evaluation (Abma et al., 2009).

This specific interpretation of responsive evaluation shares a number of basic concepts with participatory and empowerment evaluation approaches (Cousins and Whitmore, 1998; Fetterman et al., 1996; Greene, 2006; King, 2007). Evaluators in these approaches strive for social justice, equality, empowerment and emancipation (Greene, 2006; Mertens, 2009). Power and control are also shared within the evaluation process, both among stakeholders and between evaluator and stakeholders (Abma et al., 2009). If some stakeholder groups are in a vulnerable or marginalized position, the interactive techniques of participatory and empowerment evaluation can be used to give them 'a say' in the responsive evaluation process. Even though responsive evaluation shares these concepts with other approaches, this particular methodology can be distinguished by its conceptual and practical focus on hermeneutic dialogue (Widdershoven, 2001; Widdershoven and Abma, 2007). Facilitating dialogue among stakeholder groups, including marginalized or vulnerable groups, is a central task of the responsive evaluator (Abma, 2001; Abma et al., 2009). The evaluator does not adopt an advocacy position towards vulnerable groups. He does not speak *for* certain stakeholders, but supports silent groups to develop a voice for themselves to enable them to engage in dialogue with other stakeholder groups (Abma, 1997). Furthermore, it is not the sole and prime responsibility of a responsive evaluator to empower vulnerable stakeholders, but rather to enhance the dialogical process (Abma et al., 2001). The empowerment of all stakeholder groups, including those in vulnerable positions, follows from a good dialogical process in which all stakeholders involved change during the process by gaining mutual understanding of each others' perspectives and mutual learning (Widdershoven, 2001). From this dialogical perspective, empowerment is always relational (VanderPlaat, 1999).

We envision responsive evaluation as based on the notions of active participation of stakeholders from beginning to end, the value of experiential knowledge, dialogue as a hermeneutic learning process, storytelling and narratives, and a flexible and emerging design (Abma et al., 2009). The evaluator acts as a process facilitator and creates social conditions for genuine dialogue: openness, engagement, and inclusion (Abma, 2001; Abma et al., 2001). Dialogue is considered to be a vehicle for practice improvement, since it provides a place and an opportunity for stakeholders to exchange the multiple perspectives on their practice. Thereby, a fuller picture of the practice and underlying value commitments is gained and mutual learning among stakeholder groups is encouraged.

Moreover, this responsive evaluation approach gives special attention to the position and influence of marginalized or vulnerable stakeholder groups.

The methodology is characterized by four basic steps that guide the evaluator's work (Abma, 2005). These steps are respectively: 1) creating social conditions in the evaluation setting; 2) eliciting issues from different stakeholders; 3) facilitating homogeneous groups to discuss issues among stakeholders with converging interests, and 4) facilitating heterogeneous groups among stakeholders with diverging interests to bring perspectives together to enhance mutual understanding and to prepare the implementation of a shared action agenda for practice improvement.

The following sections describe two reflective narratives of projects in which we worked through these steps and paid specific attention to the issues surrounding distrust and asymmetrical relations. Reflective narratives can be seen as glimpses into evaluation practices and are grounded in the observations and experiences of the evaluator (Cousins, 2005). Reflective narratives can shed light on the complexity of interpersonal relationships in evaluation. By describing these projects as reflective narratives, we further reflect on the methodological choices that were made. Since the practices under consideration are complex and divergent, the guideline steps of the responsive evaluation approach we used had to be adapted and translated to the particularities of the contexts. By doing this we attempt to show how responsive evaluators can approach distrust and asymmetric relations in a way that transforms these challenges into opportunities to move the evaluation process forward towards practice improvement.

## **Client Councils have a Voice in Residential Elderly Care?**

In the Netherlands, the requirement to undertake user involvement of clients in the social and care sectors is laid down by law in the Participation (Clients of Care Institutions) Act or WMCZ. This act was designed to give legal rights to clients in these sectors to participate in policy and decision-making processes through advice and assent. As a result, client councils are set up in residential and nursing home organizations. Managers are expected to hold regular meetings with client councils to deliberate on policy issues that affect the clients' daily lives. In 2006, an elderly care organization commissioned an evaluation study since the central client council of this organization and the Board of Directors were experiencing frustration with the current situation. The evaluator (Baur) conducted a responsive evaluation study for six months with the objective of improving the participation practice of client councils.

There were four different stakeholder groups: eight local client councils, a central client council, the Board of Directors (one member), and seven local managers. The local client councils consisted of residents, family members and volunteers. The central client council comprised relatives and volunteers, since participation in the council was too much of a burden for residents – the task of the central client council was to deliberate on strategic policy issues. As mentioned, legislation is in place to support the participation of the local councils and the central client council in policy processes. In practice, however, participants experienced difficulties and challenges: the client councils felt that they had no influence on policy processes, and managers felt that client councils were more of a hindrance than an equal sparring partner. As one manager put it: 'They [council members] are notorious complainers.' These frustrations revealed a context of asymmetric relationships. The main issues of these stakeholders were identified and related to the communication and differing outlooks among parties. While managers were oriented towards information exchange, council members expected more horizontal deliberation. An additional tension was that managers focused on long-term strategic issues for future clients (mergers, outsourcing, etc.), whereas client council members concentrated on the daily life issues of current residents (activities, meals, gardens, etc.).

The existence of asymmetric relations and marginalized groups was a central point of attention in this evaluation project. At the start of the project, the client councils were afraid they would be judged by the evaluator and they feared that the outcomes of the evaluation would be negative for them. A very real fear was related to the dismissal of council members were the evaluator to criticize how they functioned. As far as the evaluator was concerned, this was an important indication that the client councils might possibly be experiencing being in a marginalized position in the organization. As a result, the client council's concerns about being evaluated were taken seriously. The client councils were provided with transparent information – both written and verbal – about the goal of the evaluation. The evaluator emphasized that the objective of the evaluation was to support the client councils and that their own experiences and perspectives on the value of their joint practice were central to the evaluation. Furthermore, trust was established and enthusiasm generated by continuous attention being given to these sensitivities and by establishing openness about them. One example of this was the willingness on the part of all stakeholders, including the client councils, to participate, once they felt their prior concerns had been taken seriously, and to share their concerns in public. Moreover, many stakeholders spontaneously emphasized the positive significance of the evaluation.

The role of the evaluator in this study was to illuminate how the diverse stakeholder groups experienced and valued their collaboration and participation in policy-making processes. The main stakeholder issues became apparent through in-depth interviews with all stakeholders, and through participant observation of gatherings between client councils and managers. The evaluator also facilitated a homogeneous dialogue group for client council members in order to gain more in-depth information about these issues in a safe environment. A storytelling workshop with the dialogue group was organized to enhance the exchange of experiences of the client councils members in the safe environment of the homogeneous group. The facilitator ensured that everyone had an opportunity to have their say in equal measure. She encouraged the participants to share their stories by asking reflective questions and by focusing on participants' shared experiences. The issues that were discussed pertained to the numerous difficult policy-related reports that the client councils were expected to study. What made matters worse was that these reports were often handed to them too late. The client councils felt that they had no influence on policy issues, since the management team had already dealt with the topics and set them out in these policy reports. The subjects of real importance to clients in their day-to-day life received scant attention in the client council meetings. The client councils hoped that there would be more attention to these life-world topics.

Client council members – two from each local client council – exchanged their experiences and learned from each other through dialogue. The client council members found recognition among themselves (concerning negative experiences), and inspiration (through the positive empowering success stories of some client councils). They learned that there was a way out of feeling marginalized in the communication with managers, which was a central issue of concern for the client councils. Instead of being a victim of power imbalances, they recognized that it was possible to free themselves by creating a more proactive attitude towards managers. For example, they discovered that experiential knowledge was complementary to professional knowledge, and that speaking up and joining in on seemingly remote policy issues was a way to have a say in these developments and to serve the interests of current residents. As one of them put it: 'No more grumbling among ourselves. Speak up.'

Further, a homogeneous dialogue group with managers was organized to reflect on their issues and to exchange ideas about how they could deal with client councils. Here, recognition and inspiration were also important features of the dialogue. Managers learned, for example, how their own attitude, i.e. being supportive or directive, or just giving and asking for information, influenced the

quality of their client council. They also learned that it could be useful to make policy decisions ‘from below’. For example, one of the issues managers raised was that they sometimes felt as though the client council was just complaining about ‘trivial’ matters, e.g. about the temperature of the potatoes. However, what they did learn from each other was that they could also take these complaints seriously and undertake activities together with the client council to look for ways to improve the meals, for example by going to a kitchen where the meals were prepared differently from the kitchen in their own residential care home. After this homogeneous phase, in which client councils and managers exchanged their experiences separately in a homogeneous setting, the evaluator brought the representatives of all stakeholder groups together in a heterogeneous dialogue to enhance their mutual learning and to formulate a joint agenda for practical improvements. This improved mutual respect and understanding. For example, managers realized how they sometimes belittled and patronized council members. The result was consensus about the actions to be taken.

<i>Period</i>	<i>Activity</i>	<i>Details</i>
April–August 2006	Creating social conditions & Generating stakeholder issues	<ul style="list-style-type: none"> <li>• Participant observations of council gatherings and group interviews with local client council (one per location, total: 8)</li> <li>• Participant observation of central client council gathering (1)</li> <li>• In-depth interviews with various respondents (total: 14)</li> </ul>
August–October 2006	Homogeneous groups	<ul style="list-style-type: none"> <li>• One storytelling workshop with 14 members from local client councils</li> <li>• One focus group with 4 local managers</li> </ul>
October 2006	Heterogeneous group	<ul style="list-style-type: none"> <li>• One storytelling workshop with members from local client councils, members from central client council, local managers, member of management team and Board of Directors (total: 15)</li> </ul>

**Figure 1.** Overview of Evaluation Activities in the Baur Project (Client Councils)

## Evaluating the Development of an Experimental Psychiatric Treatment

A new, experimental psychiatric treatment has been developed in the Netherlands for psychiatric clients admitted for severe drug abuse (i.e. marijuana, amphetamines, etc.), whose treatment has stagnated. As one nurse put it, there was a need for a programme ‘to gain control over the chaos’. The new approach involved a coerced detoxification programme in which a small group of clients were admitted for three months to a sheltered area of the psychiatric care institution. As a result they would be given a competent diagnosis that determined which symptoms resulted from a psychiatric illness and which symptoms could be attributed to drug abuse. The expectation was that, once these clients had been ‘clean’ for a prescribed period of time, they would be sufficiently motivated to make a fresh, constructive start with their general psychiatric treatment. This approach was experimental and unique, since the general belief is that coercive measures and the development of internal motivation are mutually exclusive.

The objective of the evaluation was to formatively support and describe the development of the experimental programme, including any expected or unexpected effects and challenges to its implementation, and to formatively make practical improvements by fostering dialogue among stakeholders. The stakeholders in this setting were the group of clients, their families, the psychiatrist, nursing staff, social workers and managers. The evaluator (Van Elteren) was embedded in the daily practice of the ward in order to be in a position to witness the quick changes expected in the development of the programme, and also to involve the patient group. The evaluation had an emergent design and a formative aim. As such it shares the developmental aims that Michael Patton describes in his work on developmental evaluation (Patton, 1994). However, the evaluation was primarily responsive since the basis for the evaluation was rooted in the involvement of plural stakeholders, dialogue and mutual learning.

One considerable challenge in the evaluation was to establish a relationship of mutual trust between the evaluator and the client group. The clients were mainly young men in their early twenties suffering from schizophrenia. They had a long history of severe drug abuse and also a history of coercion in a psychiatric institution. Gaining their trust and cooperation was important, because clients' experiences were crucial for determining the effects of the treatment and for eventually being in a position to make improvements. The evaluator had to establish a rapport with the patient group.

These clients were reluctant to trust anybody with the slightest association with the institution. The evaluator felt that the clients put his trustworthiness to the test. They initially remained distant because they wanted to ascertain exactly what the role and motivation of the evaluator were, and to see if he was in a position to force them to cooperate. Voluntariness became the key to building trust, particularly since the group had, on several occasions, already experienced coercion and they were disposed to say what others wanted to hear. However, client participation was eventually optimized because strict confidentiality was assured and maintained throughout. Although the evaluator was explicit about the reason for his being there, he simply waited for the clients to show an interest in participating in the evaluation. During the first few months he made sure he was around and visible and he spent time building personal relationships with the patients. When participating in daily activities, such as playing table tennis, drinking coffee and smoking cigarettes, he related to them as a friend. These clients were used to staff members who always maintained a professional distance. The evaluator did not remain at a distance but chatted with clients about their daily experiences, or about what he'd been up to the previous weekend. He also had fun with them. Humour is an excellent instrument for easing the atmosphere and for creating a feeling of mutual respect and equality.

Patience and an ability to alleviate tension, based on a profound attitude of respect and equality, proved essential in establishing a close rapport with these clients. After a while, a few patients expressed an interest in participating in the evaluation. However, their limited concentration span and the formal interview setting did not really encourage them to talk openly. When it became clear that standard interviews with these clients would not work, the period of time the evaluator was present and could have frequent informal conversations with them was extended. The evaluator kept a logbook with notes of the 'interview' fragments and summarized recurring themes and general issues. At a later stage, these logbook fragments were shared with the individual client to verify the evaluator's interpretation and to ask the client's permission to use the analysis in the evaluation process.

Another challenge was that the treatment surrounding coerced detoxification had to be developed and evaluated along the way. There was no existing algorithm of the means–end relationship, nor was there consensus on the goals of the treatment (no programme theory) and process of implemen-

tation (process theory). Furthermore, coercive treatment may raise questions and discussion among stakeholders in the wider context of institutions. The high degree of ambiguity in the setting created all kinds of tension and soon gave rise to conflicts relating to distrust and power imbalances.

The first conflict arose when the psychiatrist disregarded the care programme that the nurses had developed for the treatment. He forced through a number of changes in the treatment design without being transparent about his reasons for doing so or without even referring to the plan the nurses had developed. These changes were based on the psychiatrist's fear of societal response to the treatment and legal complaints, but he did not communicate this with the nurses. As a result, the nurses could not understand his decisions and questioned his vision. Feeling unheard and powerless, their commitment to the project waned. Shortly afterwards, a second conflict between the nursing staff and the psychiatrist arose. The new, more intensive treatment shed light on pitfalls in the communication processes on the ward, concerning, for example, motivation enhancement strategies or

<i>Period</i>	<i>Activity</i>	<i>Details</i>
September–November 2007	Preliminary research, Exploring prerequisites for evaluation, creating social conditions and gathering stakeholder issues.	<ul style="list-style-type: none"> <li>• Participant observations on the ward. (several days a week). Including all structural and many ad hoc meetings of staff members, such as weekly patient equipment, many daily transfers, and all project-specific workgroup meetings.</li> <li>• Daily participant observations within the patient group.</li> <li>• In-depth interviews with various professional respondents (total: 12)</li> </ul>
December 2007–August 2008	In-depth exploration and description of project developments and issues, and creating mutual learning processes between different stakeholders	<ul style="list-style-type: none"> <li>• Continuation participant observations on the ward (several days a week), including most structural and ad hoc meetings.</li> <li>• In-depth interviews with various professional respondents (total: 20)</li> <li>• In-depth interviews with family members (total: 6)</li> <li>• On the fly 'interviews', logbook notated, with patients (total: 5 patients were followed intensively, 12 less intensively)</li> <li>• Homogeneous focus/work group with nursing team (total: 8), with treatment team (4), with project management (2).</li> <li>• Heterogeneous focus groups between all members of the ward staff (2).</li> </ul>
September–December 2008	Structural integration and embedding of evaluation findings in ward processes and treatment procedures.	<ul style="list-style-type: none"> <li>• Homogeneous focus/working group with nursing team (3)</li> <li>• Heterogeneous focus days with multidisciplinary treatment team (2).</li> <li>• Homogeneous focus group with project management (1)</li> <li>• Heterogeneous focus groups between all members of the ward staff (1).</li> </ul>

**Figure 2.** Overview of Evaluation Activities in the Van Elteren Project (Psychiatric Clients)

individual patient goals. The psychiatrist communicated them directly to the clients as he was used to doing, leaving the nurses in the dark on important treatment decisions. In turn, the clients exploited the confusion that had arisen among the nurses. This added even more fuel to the already existing distrust and lack of communication between the nurses and the psychiatrist. In sum, both conflicts demonstrated the structural malfunctioning of communication between professional groups, and the power imbalances on the ward. These conflicts escalated during the first multidisciplinary focus group that the evaluator organized to establish dialogue between the nurses and the psychiatrist. The poor communication between the nurses and the psychiatrist had to be resolved and improved if the dialogical evaluation were to be successful. It was important not to let the psychiatrist lose his status as a professional, while at the same time the participation of the nurses in treatment decision-processes had to be structurally improved for them to feel part of the process. This resulted in structural arrangements, such as the introduction of a diary so that nurses could fit meetings in with their own schedule, and also in the introduction of a rule that nurses would accompany the psychiatrist when he went to see a patient. At the same time the evaluator started a series of homogeneous focus groups with the nurses on the articulation of their role in the treatment process of the patient. These focus groups were not structured as group interviews but as dialogues in a safe environment where the nurses could share their experiences. This enabled them to develop reflectivity on their own roles and responsibilities, and they felt supported by each other. They discussed the pivotal role of the nurse in the individual client's treatment plan, and their own moral obligations, for example, to bring their experiential insights to the fore in patient evaluations and decision-making procedures.

These dynamics and turbulence ultimately enhanced a mutual learning process among stakeholders, and provided an opportunity to exchange perspectives and to elaborate on the actions that had to be taken in order for the treatment programme to succeed. The evaluator had to take on an educational and even a reparative or mediating role when exchanging perspectives among the stakeholders, since a direct face-to-face dialogue between the nurses and the psychiatrist would very likely have escalated, with the clients coming out the worst.

## **Reflection on the Case Narratives**

We have described two responsive evaluation projects that have in common the existence of asymmetric relations among stakeholders and stigmatized groups. However, the contexts of these two projects differ. Consequently, the way the evaluators dealt with asymmetric relations and marginalized groups also differs. This indicates that responsive evaluation can be translated to diverse evaluation settings. From the two cases, some practical guidelines for the inclusion of marginalized groups, mutual learning and dialogue can be derived as ways to deal with distrust and asymmetric relations.

### *Inclusion of Marginalized Groups*

In the Baur project, the client councils' fear of being judged indicated that client councils believed that they were in a marginalized position. They obviously felt exposed to the critical eyes of others. In the Van Elteren project, gaining the trust of the psychiatric clients was an appreciable challenge. They approached the evaluator with considerable caution and reserve in an attempt to ascertain the exact reason for his presence. Evaluators whose aim is to involve multiple stakeholders in the evaluation are often confronted with groups of stakeholders who are reluctant to participate simply because they do not feel safe, or that they will not be listened to or taken seriously within the existing

power dynamics in the practice to be evaluated (Abma, 2000, 2001; Cousins and Whitmore, 1998; Koch, 2000; Wadsworth, 2001). However, central to participatory approaches is the involvement of as many stakeholders as possible (Abma, 2000; Cousins and Whitmore, 1998; Greene, 1997), so it is important that this challenge be faced at the outset. In responsive evaluation, creating constructive social conditions with stakeholders is the first deliberate step to be taken in the evaluation (Abma, 2001; Abma and Widdershoven, 2005). Creating good social conditions is a structural part of the evaluator's task, a normative obligation, and not just an add on or something that happens by coincidence. Paying attention to creating social conditions for dialogue is not restricted to this first phase, and continues as long as the evaluation lasts. As both projects demonstrate, this is an ongoing task for the evaluators. Both evaluators paid careful attention to the concerns of the groups that felt marginalized or feared further restrictions of voice.

Building trust takes time. The client councils' initial concerns could be overcome relatively easily by providing more information about the purpose of the project. However, only gradually during the first phase of the project did the client councils become more trusting and feeling safe about the evaluator's intentions to support them in their practice. The evaluator in the psychiatric setting opted for a less proactive role to gain the trust of the clients, since the clients were particularly sensitive about compulsion from authority figures. In all likelihood, it would have been counterproductive if the evaluator had been too proactive in his approach to the clients. So the evaluator deliberately became part of the setting by gradually participating in the clients' day-to-day life. He spent time with them, had brief conversations with them, drank coffee and smoked cigarettes. This seemingly insignificant behaviour turned out to be essential for the clients to feel safe with the evaluator. He listened to them and attempted to find out more about the real person as opposed to focusing on their mental illness and addiction. Their willingness to participate in the evaluation originated in their curiosity about the person and work of the evaluator. In both instances, trust was related to respect, reciprocity and control (Lincoln and Guba, 1985). The client council members experienced that the evaluator took them seriously, they could influence the evaluation process and become co-owners of it, and they might achieve something in terms of having more influence in the policy-making processes. In the psychiatric care setting project, clients felt respected because no force was used, and they felt that the evaluator was truly interested in them. People in both situations genuinely benefited from the evaluation instead of simply being information providers. They were accepted as people and sensed that they really could influence the making of practical improvements.

Time is an important factor for evaluators to decide how they are going to build trust among the stakeholders. The time aspect is a very practical side of evaluation studies. Van Elteren had sixteen months for his project, Baur only six months. This means that time played a role in defining the boundaries of the evaluators in investing in the building of trust with stakeholders. However, we argue that the characteristics of the setting and the presence of marginalized groups are very important in deciding how trust can be built, and how long it takes. If a more intensive process is needed to meet the needs and characteristics of the marginalized groups for them to be included, as in the Van Elteren case, evaluators should be aware that this is a basic part of the project, and that the resources need to be created for the time required to build a trusting relationship. If there is a lack either of trust or of a genuine willingness among clients to participate, then the purpose of the evaluation will be undermined.

### *Mutual Learning and Dialogue*

Enhancing mutual learning amongst stakeholders is a central feature of responsive evaluation (Abma et al., 2001; Karlsson, 2001). This can be done in several ways, depending on the context of the evaluation and the way stakeholders relate to each other. Storytelling was used in the Baur

project as a means for learning, within stakeholder groups (homogeneous) as well as among them (heterogeneous). Storytelling is a good way for stakeholders, particularly those with more silent voices in a marginalized position, to share their experiences with others (Abma, 2001, 2003). Moreover, the homogeneous setting in which the storytelling workshop first took place – only client council members – was a safe environment for them to speak up. Therefore, not only positive stories, but also negative experiences and frustrations could be articulated. This resulted in a better understanding of the issues of the client councils, both for themselves and for the evaluator. Creating homogeneous groups first, before joining in a heterogeneous dialogue with other stakeholders, is a central characteristic of responsive evaluation (Abma et al., 2009; Abma and Widdershoven, 2005). A process of mutual learning and relational empowerment within a group of stakeholders can thus be fostered. This is an important basis for the mutual learning process of stakeholders that responsive evaluators strive for in the heterogeneous dialogue that follows homogeneous dialogue (Abma, 2005; Karlsson, 2001). In Baur's project, there were no manifest conflict situations among stakeholder groups that stood in the way of fostering mutual learning through good dialogue (featuring openness, respect, engagement, and inclusion) (Abma, 2001; Abma et al., 2009). In the heterogeneous dialogue group, the client councils and managers discovered that they shared an important interest, namely the wellbeing of clients. This formed the basis for their joint agenda for practice improvements (e.g. more room for the life-world issues of clients in the local client council and more proactive agenda setting by the client councils themselves). Overall, the client councils and managers experienced the way they communicated with each other during the evaluation project as exemplary for a more dialogical interactive policy-making process.

The Van Elteren context was characterized by conflict between the nursing staff and the psychiatrist. Evaluators often encounter conflict in the practices they evaluate (Stevahn and King, 2005). If these conflicts are managed constructively, human relations will be enhanced. Cooperative negotiation skills are essential for evaluators (King et al., 2001; Stevahn et al., 2005). In this project, the evaluator worked on improving cooperation among the stakeholders. First, in an early stage of the project, the evaluator organized a dialogue group with nurses, psychiatrists and social workers. However, this attempt to engage the participants in an open dialogue failed. The participants were not able to communicate in an equal and constructive manner, since the conflicts between them were rooted in years of history. The attempt to enhance dialogue between them showed that the underlying conflicts had to be dealt with first. Mutual learning had therefore to be fostered in a different way.

The evaluator chose a more strategic approach to enhance mutual learning among the stakeholders. He spoke with the programme leader of the coerced detoxification project about the creation of a new set of structural arrangements on the ward, by which the psychiatrist, social worker, nurses and clients were supported to communicate with each other in the daily practice on the ward. At the same time the evaluator started up homogeneous groups with nurses about their role in the treatment process of clients. By doing this, the nurses felt supported in defining their own value, significance and responsibilities. They experienced this as empowering. Further, the evaluator played a mediating and educational role in the conflict situations between the nurses and psychiatrist. He spoke individually with the psychiatrist and with the nurses. Instead of confronting them physically with each other in an open dialogue, the evaluator brought the perspectives and experiences of both parties into his conversations with them. As an educator, he explained to the psychiatrist how the nurses felt and vice versa. The result was that the stakeholders learned to understand the perspective of the other and this eliminated emotional hindrances. Consequently, the evaluation project could proceed with the focus on improving the processes on the ward.

The evaluator could only take on this mediating and translational role because he had gained the trust of the psychiatrist and the nurses throughout the project. And he did not confront them bluntly

with the other's perspectives, but was sensitive about how he formulated them. It was important to make sure that the person he spoke with felt understood and taken seriously, before carefully introducing the perspective of another stakeholder into the conversation. In other words, the evaluator performed multiple partiality (Abma, 2006; Abma and Widdershoven, 2008). Even though conflict situations did not arise in the project with the client councils and managers, the evaluator in that project also had to perform multiple partiality to bring the issues of client councils and of managers to the fore. It is a prerequisite for facilitating mutual learning and dialogue that the evaluator is accepted by all parties. All stakeholders have to feel that they are heard and that their issues and concerns are taken into account by the evaluator. Evaluators should be explicit about this multiple partiality to avoid misunderstanding about their attitude (one group of stakeholders could feel more appreciated by the evaluator than the other if they do not know what the attitude of the evaluator towards them stems from – with the risk of negative consequences for the entire process).

## Conclusion and Discussion

Taking practical examples derived from two responsive evaluation projects, we have shown that, even though distrust and asymmetric relations among stakeholders can confront evaluators with challenging situations, dealing constructively with these challenges is not impossible. Asymmetric relations can at first sight be hidden in the evaluation project, but can quickly rise to the surface when the responsive evaluator starts creating social conditions and collecting stakeholders' issues. The same can happen if feelings of distrust among stakeholders and towards the evaluator exist.

In responsive evaluation these challenging situations are deliberately anticipated and used constructively by the evaluators in order to establish the conditions for dialogue and collaborative practice improvements. We have described how responsive evaluation, focusing on the inclusion of marginalized groups, mutual learning and good dialogue, can offer a number of guidelines for other evaluators who work for inclusive, participatory evaluation processes. Knowledge of and sensitivity to social dynamics, intensive engagement, reciprocity and the capacity to change roles and responding actively to the dynamics of the process are then competences the evaluator requires in addition to more traditional social scientific skills in data collection and analysis.

Furthermore, we have seen that taking time to involve marginalized groups in the evaluation is important to set basic preconditions for establishing communication among stakeholders. However, the opportunity to take this time rests largely on the willingness of the funding organization of the evaluation project to support this. In this sense, those who commission the study are also stakeholders (Abma and Schwandt, 2005). An evaluator should be transparent about challenges that occur during the evaluation process and justify choices he makes in the evaluation design, so that mutual expectations and needs are clear to all parties.

Another important issue discussed here is the concept of dialogue. Dialogue is defined by some basic conditions, namely openness, respect, engagement and inclusion (Abma et al., 2001). However, we have seen in the Van Elteren case study that open dialogue, in terms of a physical meeting of parties, is not always possible. Particularly when relations are tense and when conflicts among stakeholders are latently or manifestly present, bringing stakeholders together for dialogue can be counterproductive or even cause the conflict to deteriorate. This was what happened when the nurses and psychiatrist in the Van Elteren case were brought together at the start of the project, and similar situations have been reported elsewhere (Abma, 2006). In these kinds of cases, evaluators should not conclude that dialogue is simply impossible, since a learning process can only get under way if stakeholders have an insight into the frustrations and experiences of others (Widdershoven, 2001). Dialogue can be created virtually by the mediation of the evaluator (as Van

Elteren did) or by the use of stories (Abma, 2003; Abma and Widdershoven, 2005) as an alternative for a heterogeneous meeting with stakeholders in conflict.

One could ask whether dealing with asymmetric relations can or even should be a part of the evaluator's work, or more generally, how the active role of the responsive evaluator in the evaluation setting can be theoretically underpinned and justified. In our approach to responsive evaluation, we consider establishing a dialogue among stakeholders as crucial in order to build reciprocal relationships within the evaluation process. Instead of reaching consensus on problems or future actions, or negotiating between stakeholders, a dialogue here is seen as a means to engage mutual understanding among stakeholders and to gain respect across differences (Abma et al., 2001; Schwandt, 2001). When asymmetries and even conflicts among stakeholders come to the surface, it implies that the evaluator should make choices in how to deal with these situations. We argue that it is essential for responsive evaluation that the evaluator does not try immediately to ease conflict or silence powerful voices in a dialogue. Instead, evaluators should work with stakeholders towards a situation in which all feel empowered to work on practical improvements together. It is a shared responsibility of all stakeholders to solve conflicts and to learn to hear silenced voices. The evaluator can help create awareness about this and he holds a mirror up to stakeholders.

The need for justification of the active role of the responsive evaluator in this respect is therefore threefold. From a hermeneutic point of view, evaluative knowledge is constructed in mutual interactions among the stakeholders and between the evaluator and the stakeholders (Abma, 2006; Guba and Lincoln, 1989; Schwandt, 2001; Widdershoven, 2001). An evaluator is actively involved in constructing this knowledge, does not stand outside the dialogue, and should be transparent about his interpretive role and willing to reflect critically on how his interpretation influenced the findings. Pragmatically, fostering a dialogue is not an ad hoc process, but should ideally become embedded in the daily practice and routines of the stakeholders. Therefore, the evaluator is actively involved in establishing preconditions for a dialogue to occur, such as providing arrangements for parties to meet. The evaluator should be willing to reflect on the quality of this process, in terms of its fairness (Did all the stakeholders 'have a say?') and its authenticity (Was the personal understanding and the mutual understanding of the stakeholders enhanced? Did they gain more control over the future of their practice and develop shared actions to improve the practice?) (Guba and Lincoln, 1989).

Third, from a normative point of view, responsive evaluators strive for dialogue that is inclusive (particularly when including marginalized groups), deliberative and promotes equity and fairness among stakeholders (Greene, 2001a). Responsive evaluators therefore have a value-committed stance towards practices; they actively promote and communicate certain norms and values (Greene, 2001b, 2002; Schwandt, 2002, 2008). The value-committed stance of the evaluators in the two projects described here is characterized by striving for democratization, social change and human flourishing (balancing autonomy, cooperation and hierarchy) (Niessen et al., 2009). We assume that it is impossible to be value-free in evaluation; evaluators bring with them their own value commitments. The methodology and theory they use imply certain values and the practice itself also expresses certain values. Therefore, we argue that evaluators should be open and explicit about their values. Yet responsive evaluators do not just have a value commitment – they actively promote values of social justice, participation and dialogue. It is useful for evaluators to openly discuss these value commitments and their translation to a particular context – with the stakeholders in the setting, but also with peers and experts in the field. When stakeholders know from which value-committed stance the evaluator will work, the basis is laid for building trust between evaluator and stakeholders, and among stakeholders. Dealing with asymmetric power relations and possible conflicts between stakeholders can then commence.

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