Can reflexivity be learned? An experience with tobacco control practitioners in Canada

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Summary

To explore an example of a reflexive intervention with health professionals working in tobacco control (TC). This study reports the perceived intervention effects regarding: (i) participants’ understanding of reflexivity and personal learning and (ii) conditions needed in order to integrate reflexivity into professional and organizational practices. This is a qualitative study using an interpretative evaluation framework to assess the perceived effects of a reflexive intervention in Montréal, Québec. Semi-structured qualitative interviews ($n = 8$) gathered data. Data analysis began deductively, guided by the broad categories found in research questions. Sub-categories to populate these broad categories captured the inhibitors and facilitators through an inductive thematic analysis. Our study reveals that, following the intervention, most participants had a generally good understanding of reflexivity and described concrete learning in association with the intervention. Main facilitators and inhibitors to conducting a reflexive workshop pertained to the organizational context as well as to the professional and individual characteristics of the participants. Some participants implemented sustainable changes as a result of the intervention, such as creating a tool, reviewing work plans and developing new mechanisms to integrate the voice of their clientele in the planning process. The need and interest for dialogue among health professionals about how TC intervention activities may inadvertently contribute to social inequalities in smoking is apparent. While there appears to be potential for reflexive practice, the integration of reflexivity into practice is reliant upon the organizational context (financial and time constraints, culture, support, and climate) and the reflexivity concept itself (intangibility, complexity and fuzziness).

Key words: intervention, program evaluation, qualitative methods, tobacco

INTRODUCTION

Reflexivity has been introduced into health promotion as a means of generating knowledge from experience for the improvement of practice and research (Eakin et al., 1996; Issitt, 2003; Murry and Poland, 2006; Wright, 2012; Tremblay et al., 2014). In fact, reflexivity can be conceived as an intended and conscious intellectual investigation in which individuals (or groups) question their
experiences to develop new understandings and knowledge that are ultimately reinvested to transform their actions (Dewey, 1910; Boud et al., 1985; Mezirow, 1991; Kember et al., 1999; Delany and Watkin, 2009; Mann et al., 2009; Tremblay and Parent, 2014). Beyond improving health promotion planning and practice, this form of critical investigation has also the potential to support health promoters in their roles as engaged and invested social actors, helping them to become aware of the power, moral and social issues underlying their practice (Issitt, 2003; Murry and Poland, 2006; Ledwith and Springett, 2010; Tremblay et al., 2014).

Although reflexivity is an essential attribute of a competent professional and has generated a huge body of theoretical work (Mann et al., 2009), empirical work around the development of this capacity is limited. We know little about how health practitioners become reflexive and how reflexivity impacts their work (Wong et al., 1995; Kember et al., 1999; Issitt, 2003; Mann et al., 2009). This paper presents an example of a workshop intervention aiming to catalyse reflexive thinking among tobacco control (TC) professionals where participants were invited to conduct a reflexive workshop in their own work environments to spread reflexivity in their organization or professional network. Using an interpretative perspective building on the participants’ experiences, this paper describes perceived intervention effects by focusing on (i) participants’ understanding of reflexivity and personal learning and (ii) conditions needed in order to integrate reflexivity into professional and organizational practices.

**REFLEXIVITY IN HEALTH PROMOTION**

Often described with terms such as ‘critical reflection’, ‘self-critical dialogue’ and ‘reflexive practice’ (Kippax and Kinder, 2002), reflexivity is more than a simple reflection. Reflexivity stems from reflexive practice, a concept principally articulated by Schön (Schön, 1983). Reflective practice implies that the product of reflection is reinvested in professional’s actions, allowing him/her to better cope with complex practice situations and problems (Schön, 1983; Bleakley, 1999). Reflexivity aims to bring about transformations in practice through inter- and intra-subjective learning in order to broaden the practitioner’s understanding of their own identity and the identities of others’ in order to take action from an emancipatory point of view (Kippax and Kinder, 2002).

In this paper, reflexivity is defined as a critically transformative practice allowing one to: (i) question personal/professional assumptions, goals, value frameworks and strategies, (ii) identify the existence, nature and impacts of unequal power relations and (iii) transform individual and collective thoughts, discourses and actions through which social inequalities in health are created and/or maintained (Poland et al., 2006; Ledwith and Springett, 2010). Reflexivity thus includes an analysis of moral, ethical and power issues that question and challenge current practices (Tremblay et al., 2014). Professionals engaged in reflexivity consider power relations both in terms of their own practices and in terms of the situation of the people they are trying to reach in their work (Ledwith and Springett, 2010; Wright, 2012). Health promotion practitioners are often faced with health inequalities which take root in broad power relations embodied in interpersonal relationships, institutional practices and policies (Eakin et al., 1996; Coburn, 2000, 2004; Scambler, 2001; Labonte, 2004; Navarro and Muntaner, 2004). In this context, reflexivity is proposed as a means to increase practitioners’ awareness of these power dynamics, to forge anti-oppressive practices and to assist work towards overcoming inequalities by acting on structural and political determinants that reproduce and maintain power imbalances.

Notwithstanding the increasing interest in reflexivity in health care and health promotion, understanding of how reflexivity can be operationalized and catalysed among health practitioners is limited. ‘Despite reflection’s currency as a topic of educational importance, and the presence of several helpful models, there is surprisingly little to guide educators in their work to understand and develop reflective ability in their learners’ [(Mann et al., 2009), p. 596]. Some studies have demonstrated that reflexivity can effectively be stimulated and developed in certain specific contexts related to education and professional development (Beecher et al., 1997; Sobral, 2001, 2005; Williams and Wessel, 2004; Mann et al., 2009). Others have shown that reflexivity can be hindered or facilitated by a variety of factors, ranging from organizational support and type of organizational hierarchy, support of a small group of colleagues or a mentor, time constraints, the professional’s number of years of practice and the individual predisposition to reflection (Beecher et al., 1997; Platzer et al., 2000; Teekman, 2000; Gustafsson and Fagerberg, 2004; Mamede and Schmidt, 2005). However, most of these studies analysed reflexivity using quantitative methods without delving more deeply into a comprehensive understanding of how reflexivity might be intentionally developed and catalysed. Importantly, most of these studies were conducted with students, such that transferability of their conclusions to the field of health promotion in general and professionals in particular is questionable (Mann et al., 2009).
A REFLEXIVE WORKSHOP FOR TC PRACTITIONERS

Context
Public health and health promotion practitioners working in TC are faced with delicate challenges in their current efforts to continue to bring smoking rates down. Between 1950 and 2011, the prevalence of smoking (including daily and non-daily smoking) among adults aged 20 years and older in Canada decreased steadily from 68.9 to 18.6% (Corsi et al., 2014). This is one of, if not the major public health success story in the last century. Despite these remarkable population-level declines, however, social inequalities are increasingly differentiating tobacco users from non-users with smoking prevalence and incidence following a progressively steeper social class gradient. Across all age groups people of lower educational attainment, in working class occupations and lower income levels have a higher rate of uptake and lower rate of decline in smoking than other social categories (Smith et al., 2009; Corsi et al., 2014; Reid et al., 2014). These results are perplexing and public health researchers have begun to question whether the design, and implementation of population-level interventions and policies regarding smoking may be participating in the exacerbation of social inequities in smoking (Petticrew, 2011; Lorenc et al., 2013; Lorenc and Oliver 2014). In fact, the social gradient in smoking also applies to the uptake of messages disseminated by population health interventions (Frohlich and Potvin, 2008; McLaren et al., 2010).

Social inequalities in smoking can be viewed in terms of broader power relations in society embodied in interpersonal relationships and institutional practices and policies that reproduce inequalities over time (Eakin et al., 1996; Coburn, 2000, 2004; Scambler, 2001; Labonte, 2004; Navarro and Muntaner, 2004). A mismatch in fundamental assumptions and lived experience between middle-class professionals creating interventions, and their socially excluded ‘clientele’, might be contributing to the diminishing marginal returns on investment in population-level TC (Poland, 1998; Frohlich et al., 2012). This growing social distance between TC and (particularly socio-economically disadvantaged) people who smoke seems to have had the effect of making the already ‘hard-to-reach’ groups even harder to reach (Paul et al., 2010) and further marginalizing and stigmatizing people who smoke (Bell et al., 2010; Ritchie et al., 2010). Little has been written about the power dynamic between the ‘expert’ professional and the ‘target’ population when it comes to TC. Procedural guidelines on effective collaborations in community health between community members, professionals and researchers (Israel et al., 2006; Seifer, 2006) only partially illuminate these power dynamics. Unequal power dynamics are identified by Popay et al. (Popay et al., 2008) as one of four dimensions describing the processes of social exclusion. The dominant reliance upon epidemiological methods to define and circumscribe health needs, with a concomitant neglect for sociological research permitting local voices and opinions to be heard, provides an example of how professionalism in public health can perpetuate inequalities in health (Popay and William, 1994). Indeed, narrative data from in-depth interviews reveal that people living in disadvantaged neighbourhoods recognize higher exposure health risks in their neighbourhood related to a range of factors including accidents, pollution and leisure opportunities (Popay et al., 2003).

Given that social strata are created and maintained through numerous taken-for-granted and socially ‘invisible’ practices of exclusion and social differentiation (Bourdieu, 1984; Grabb, 2002; Gattrell et al., 2004), the well intentioned practitioner may be unaware of the extent to which ‘risk behaviours’ are influenced by social identities, and thus the potential for ‘symbolic violence’. For Bourdieu, symbolic violence refers to the way in which narratives which valorize some people over others (more healthy, ‘together’, desirable, etc.) are taken as ‘self-evident’ (Wacquant, 1993). In health promotion for example, the valorization of future-oriented ‘care’ of the body/self and the assumed impulse to risk reduction represents an imposition of middle-class sensibilities. Disadvantaged populations are alienated because they do not see their lived realities reflected in these normalized assumptions touted as universal, for the most part, by middle-class professionals’ own image. Not seeing themselves reflected in health education, the marginalized conclude this is ‘not for the likes of them’ and as a further example of how they do not count, are invisible, do not matter, and are seen as a nuisance. In this way, health promotion initiatives, even those informed by an explicit commitment to health equity, risk to reinforce and exacerbate social inequities in health (Poland, 1998; Poland and Holmes, 2009).

The intervention
The premise of this study is that a reflexive practice may influence how health promotion practitioners approach TC interventions and help them to recognize that their practice may reinforce health inequities and marginalize certain groups (Poland et al., 2006; Ledwith and Springett, 2010). To explore this issue we (M.T.W., B.P., K.L.F.) developed a knowledge translation (KT) project, funded through a grant from the CIHR, which aimed to
work through issues of reflexivity with participants and build their capacity to do the same with other practitioners. The format was a workshop based on a video, we developed in an earlier research project entitled ‘Different Smokes: Creating a reflexive space for tobacco control with youth’ exploring the issue of social inequities in Canadian youth smoking.

Our video focused on youth smoking as adolescence is a critical period during which people are initiated to smoking and take on smoking as a regular habit (Ellickson et al., 2004; Hu et al., 2006). Understanding the conditions under which people begin to start smoking holds potential for reducing social inequalities in smoking. The material in the video was drawn from focus groups with youth who smoke in Montreal and Vancouver, as well as from interviews with TC practitioners from these same cities. We sampled youth who smoke from schools that scored either very high or very low on socio-economic indices. School nurses recruited youth for the focus groups based upon on a question used by the British Colombia Youth Survey on Smoking and Health II: ‘How would you describe your household’s financial situation (how much money your family has)?’ (A) very well-off; (B) well-off; (C) a little above average; (D) a little below average; (E) below average; (F) poor. Those responding A, B and C were considered high socioeconomic status (SES), with those responding D, E and F considered low SES.

The video highlights differences regarding the meanings assigned to smoking as well as the experience of smoking between practitioners and youth—particularly low SES youth. The explicit goal of the film was not to ‘teach’ anything about smoking and youth, but rather to provide TC practitioners with the opportunity to reflect on their practice and to consider how the differences in their perceptions might be contributing to social inequities in smoking. Participants in the workshop were first shown the video and then trained to use this tool to help moderate their own reflexive workshops. The aim of this intervention was to: (i) create a reflexive experience among participants and (ii) create the conditions necessary for participants to extend this experience into their work setting(s) and professional networks.

Participants in the workshop consisted of nine TC practitioners from across Canada. We defined a TC practitioner as any health professional, or program developer, who has as a major part of his/her job mandate the prevention or cessation of smoking among youth. Our project began with a 2-day workshop in February 2011 in which, on the first day, the practitioners were themselves participants in this national reflexive workshop. On the second day, they were trained to run a similar workshop with their own colleagues. We asked these newly trained ‘trainers’ to report back to us at a final meeting in September 2011 regarding the strengths and weaknesses, problems and solutions from their experiences.

METHODS

Design

This is a qualitative study of an intervention provided to TC practitioners whereby intervention effects are assessed with an interpretative framework. Intervention effects have traditionally been measured with experimental or quasi-experimental designs (Brousselle et al., 2009). Such designs are, however, not always possible or desirable (Mayne, 2012). An interpretative inquiry is a valuable option to assess generative causality and to explore how the effects of an intervention are produced (Shaw, 1999). Indeed, empirical research demonstrates that participant responsiveness and interpretation of the intervention in terms of involvement and interest predict intervention outcomes (Berkel et al., 2011). Narrative inquiry allows practitioners to share their experience with interventions and in so doing, provides unique insight into the complexity of health promotion interventions (Riley and Hawe, 2005).

Participants

Participants were invited to the national workshop with the aim of achieving national representation and reach of professionals engaged with TC interventions. Contact with potential participants was made through public health networks to which the research team had prior professional collaborations. The national workshop involved three practitioners from British Columbia, one practitioner from Manitoba, one practitioner from Toronto, two practitioners from Nova Scotia and three practitioners from Quebec. No programme participants reported having prior experience or knowledge of reflexive practice. All participants were invited to take part in a qualitative interview about their experiences over the course of the project; eight TC practitioners of the initial nine from our KT project were successfully contacted and all agreed to be interviewed. All but two participants were female. The number of years working in TC ranged between 8 and 15 years, with the exception of one participant who had 3 years of experience. Five participants worked at a regional (or local) health directorate and three worked for a non-profit disease prevention advocacy organization.

Data collection

Semi-structured qualitative interviews were used to gather the data. All interviews were completed by the first author (S.B.) at the end of the intervention (between November 2011 and January 2012). Open-ended questions were
Can reflexivity be learned?

Participants’ understanding of reflexivity

Interviews revealed that most participants had an understanding of reflexivity that corresponded to the content of the national workshop and to definitions found in the literature. Most participants were able to identify key elements of this kind of activity including: a process of critical questioning resulting in an explicit recognition of their own assumptions, biases, and values and leading to the identification of unintended and potentially undesirable impacts of practice. For instance, one participant mentioned:

From my perspective, reflexive practice is to look at the overall process of what it is that we’re trying to do, reflect on our own views, biases, and assumptions, in terms of how that affects what we’re actually going to develop ( . . ).

In the same view, another participant explained:

I guess [reflexivity] is intentional (. . .) reflection about your values, and your assumptions, and your place in the world, and how that impacts the way you approach your work with the clients that you’re working with.

Because reflexivity implies an increased awareness of our assumptions and how they forge our view of experience, some participants also highlighted that this kind of activity can widen an issue such that it can be seen through multiple lenses, or ‘to look at it from another perspective’. In this context, many participants believe a reflexive process needs to integrate the voice of their ‘target population’, in order to increase the relevance of intervention planning:

[Reflexivity] is asking people ‘Who perhaps is the target that we’re working for, or what are we trying to accomplish? Who is the target audience? Do we have people around the table that are representative of the target group? How are we ensuring that their voice is being heard?’ (. . .) We need to be sure that we’re getting the voice of the people that we’re developing a program for.

Acknowledging this need, many participants emphasized the developmental use of reflexivity, as an activity allowing them to identify new ways to intervene with their clients:

[Reflexivity] is focused on practice, how to develop practice and how to do it differently.

Some participants accentuated the process elements of reflexivity (‘unstructured discussion around an issue’) rather than the content elements (goals and functions of reflexivity, for instance). In fact, not all participants were sure of how, in practice, reflexivity would be distinct from having an open, non-directive and non-judgmental discussion about work practices and their relationship with youth ‘clientele’.

Participants’ learning from the national workshop

Overall, participants’ perceived the national workshop as having achieved many of its anticipated effects. In fact, this

used to investigate: (i) participants’ understanding and perceived utility of reflexivity (i.e. what reflexivity is, and what it looks like in practice; how it compares to other types of interaction among practitioners regarding their work), (ii) their experiences during the workshop (i.e. how their interest developed over time, if their experience met expectations, what they felt they had to gain or lose from participating, what they may have learned) and (iii) their experience as trainers (i.e. organizational conditions surrounding workshop occurrence, alignment between the aims of reflexivity and those of their organization, the potential for reflexivity to become routinized in their work setting). All interviews but two were conducted over the telephone or by Skype. The interviews lasted ~1 h.

Data analysis

All interviews were recorded and transcribed verbatim. The analytic process was based on a thematic content analysis (Patton, 2002). First, we developed a coding scheme based on the categories found in our research questions. Our analysis began with a deductive approached whereby data were grouped into participants’: (i) understanding of reflexivity, (ii) main learning from the national workshop, (iii) capacity to hold a local reflexive workshop in their organizational setting, (iv) perceived ability and interest to integrate reflexivity into their own practices and (v) perceived opportunities for reflexivity to become integrated into their organizational work environment. While these broad categories were initially based on the research questions, sub-categories to populate these categories capturing the inhibitors and facilitators were analysed inductively through a thematic analysis. This highlighted core meanings and strong recurrent patterns in participants’ answers. In preparation for coding, two members of the research team (S.B. and M.C.T.) worked together to agree on the coding and adjust the coding schemes. Coding was mainly performed by one coder (M.C.T.), and checked by a second coder (S.B.) to ensure validity of the coding scheme and consistency of the analysis. Coding disparities were explored and resolved by consensus between the two coders.

RESULTS

Participants’ understanding of reflexivity

Interviews revealed that most participants had an understanding of reflexivity that corresponded to the content of the national workshop and to definitions found in the literature. Most participants were able to identify key elements of this kind of activity including: a process of critical questioning resulting in an explicit recognition of their


workshop allowed most participants to revisit their experience of practice in a reflexive manner. Many participants highlighted the importance of an increased awareness of the assumptions, values and bias underlying their professional practices, as well as the way these preconceptions influenced their work. One participant eloquently explains how the workshop helped him/her become conscious of his preconceptions and how this impacted his/her work in an unintended way:

What I learnt is, we need to take the assumptions that we have, especially in the tobacco control community, [for what they] are exactly, assumptions (…). One of the things that has come from this project certainly, is looking at the unintended consequences of our policies and laws. (…) We did a great job in the last ten years, you know, getting tobacco control legislations and policies in place, but what we’ve also done is we’ve put people in a corner, and those people are the people we’re trying to help. And we’ve thrown them in a corner, and made them put up a defensive wall.

Likewise, some participants learned the importance of reflexivity itself, the significance of taking time to reflect and being critical about their practice. One participant deplored:

I think we just roll, every year, our work plans into what we think we need to do, rather than really sitting back and thinking about it critically and [asking] is this really what the people who we’re trying to reach want us to do, is that really what they need, and what they want us to do?

However, while all participants recognized the importance of identifying assumptions, values and bias, few explicitly identified their own preconceptions regarding youth smoking behaviour. In some instances, however, participants were more specific and pointed out certain practices (e.g. characterizing people who smoke as ‘abnormal’) as being unacceptable, or highlighted new understandings of concepts (e.g. dependence, smokers) they developed as a result of participating in the workshop. In this regard, one participant mentioned:

The terms like ‘smoker’ (…). It’s a label, and we use it all the time. We use it in health education resources, we use it in our ads, and yet, we’re labelling people. (…) On our website, you could click on certain things, and there was a person living with asthma, and then the second one was a smoker. Why did we say asthmatic? Why didn’t we say a person living with asthma and a person who smokes?

Participants were drawn to the national workshop by the theme of the intervention and the possibility to network and discuss with colleagues from across Canada. The experience of reflexive learning appears to have been enhanced by participants’ openness for reflection and the degree of comfort with uncertainty, as well as a willingness to feel off-balance. As some participants put it, they are for the most part ‘life-long learner(s)’ that always try ‘to put [themselves] in another one’s shoes, or another one’s perspective to try to look at this from this point of view’. Nonetheless, participants also expressed some degree of dissatisfaction with their learning from the workshop. This disappointment was often related to a lack of understanding regarding the aims of the intervention. In fact, with few exceptions, participants attended the national workshop with the expectation they would learn how they could be better at their jobs; in other words they sought answers and solutions that would enable them to be more effective in reducing smoking uptake among low SES youth, rather than question that goal (indeed, the research team also struggled to find balance between identifying solutions and providing the space for solutions among participants to emerge). In addition, some participants highlighted that the 2-day workshop was too short to achieve its goal.

Participants’ ability and interest to organize a local workshop in their own milieu

Of the eight participants who participated in an interview, seven organized (alone or in team with another participant) a similar workshop using the ‘Different Smokes’ video in their organization or professional network. One participant organized two workshops. The participant who did not run a workshop identified several barriers, including; a lack of time and financial resources to prepare and organize the activity, the absence of tangible benefits for the organization and a lack of credibility to mobilize colleagues. Overall, participants were relatively satisfied with their own local workshop, but most were often sceptical about the effect of this activity on their colleagues:

Most of the participants [in my workshop] said: ‘it’s great, we had, a conversation around youth, we talked about it as a group, but the video was not useful for us. We were happy to contribute to what you’re doing and we’re happy to contribute our comments back, but the video is not it for us.

The duration of local workshops was mentioned as reducing the potential of the workshop in the professional and organizational environment. In contrast, other participants having received requests from colleagues to repeat the experience were more optimistic about the potential effect from a local workshop:

I’ve had probably four different asks from the community of people who were at that session to do it for their
workplaces and their groups, because they thought that the workshop was that great.

Main facilitating conditions to run a workshop identified by participants were organizational openness to novelty and change, consistency of the workshop with the organization’s values and mandate, support from management, professional credibility and the authoritative position of the organizer. Principal inhibitors to run a workshop were described as a lack of time to organize and participate in the activity, complexity of the reflexivity concept that makes it hard to teach, as well as communicative and leadership abilities needed to run the local workshop.

Participants’ perceived opportunities for reflexivity to become integrated into their organizational work environment

Following the intervention, most participants expressed an interest to integrate reflexivity in their practice and to diffuse the reflexivity activity to their colleagues. However, most participants suggested that putting this interest into action may be wishful thinking. At the time of the interviews, few participants felt they implemented new practices that could be maintained in their organization over time. Still, however, some effects from the intervention are noteworthy. For instance, one participant developed a new tool highlighting the consequences of stigmatizing language. This participant also reported changes in some organizational procedures:

our work plan has really changed. You know, we went through it with a different lens, and said ‘this will and will not work, we need to talk to someone about this’ (. . .).

Others created mechanisms to include the voice of their clientele when designing messages to this public:

We’ve developed another resource for youth, and we went out and did some focus groups with the youth, and again (. . .) [reflexivity] for me, was a factor why I thought of making sure that we get the voices (. . .). I think it helped reinforce what I think is good practice.

Still others integrated new ways of thinking and functioning which they attribute as consequent to a reflexivity process:

I really learned that it’s time to look at a different way of facilitating and different way of participating, whether it’s from staff meetings to meetings in the community. (. . .) When I had to do the sessions on our [organizational] policy, I looked at it from a different perspective. I came up with some key questions that we were going to brainstorm together, and it was just assumed that whoever attended, they would be part of the solution, and not be lectured or prevented to say what they should do and why. They had to come up with their own assumptions, they had to come up with ways that they were willing to help.

Conditions identified by participants as facilitating the integration of reflexivity into professional and organizational practices included: a progressive organizational culture, an organizational openness to novelty, the presence of creative thinkers inside the organization, managerial support to carry on practice-based changes, as well as a stable and ‘psychologically safe’ organizational environment in which to try new ideas and ways of working. In contrast, the most commonly identified inhibitors were financial and time constraints, which impair the capacity to stand back and reflect in action, conservative management, a rigid organizational culture and instability in the professional environment. The complexity and fuzziness of the reflexivity concept, as well as the intangibility of its benefits, were also named as constraining factors which rendered reflexivity difficult to integrate concretely into practice and ‘to sell’ to management.

DISCUSSION

The aim of this paper is to explore and describe the impact of a workshop intervention aiming to catalyze reflexivity among TC intervention planners/practitioners and their organization and professional conditions interacting with the implementation of this workshop. Overall, our study reveals that, following the intervention, most participants had a generally good understanding of reflexivity, conceived as a process of critical questioning making explicit individual assumptions, biases, and values, and how they impact professional practice. In addition, most participants described concrete learning in association with the intervention (increased awareness of their own assumptions and how they affect their work, development of new understandings of practice and clientele, recognition of the importance of reflexive practice). However, few specifically pointed out which preconceptions they revisited or what new understandings they developed regarding youth smoking. As a part of the intervention, participants were invited to conduct a reflexive workshop in their own milieu and almost all of the interviewed participants managed to do so, even if their satisfaction levels in regard to this experience varied greatly. In this context, main facilitators and inhibitors pertained to the organizational context as well as to the professional and individual characteristics of the participants. Finally, even if most of participants expressed a willingness to integrate reflexivity into their professional and organizational routines, few believed they were capable of
doing so. Some participants implemented sustainable changes as a result of the intervention, such as creating a
tool, reviewing work plans and developing new mechan-
isms to integrate the voice of their clientele in the planning
process. From the participants’ point of view, the integra-
tion of reflexivity into practice is reliant upon the organiza-
tional context (financial and time constraints, culture,
support, climate) and the reflexivity concept itself (intangi-
bility, complexity and fuzziness).

These results highlight the presence of important chal-
enges to incorporating reflexivity into an organizational
routine. Professionals concerned with becoming more ef-
fective look for solutions through the acquisition of new
knowledge, materials, resources and/or ideas. In this con-
text, thinking and dialoguing critically about what is cur-
rently being done and how, risks being seen as ineffective
as it is not ‘actionable’ in the same ways as routinized prac-
tice. It would therefore appear that ‘goal free’ processes
characteristic of reflexivity, which do not seek concrete so-
lutions or answers, must somehow be reconciled with the
reality of professional and institutional requirements for
productivity, performance and accountability if reflexivity
is to have a place in the planning of population health in-
terventions. In this respect, integrating reflexivity into ex-
isting formal mechanisms may be a possibility. Here, some
participants suggested creating a list of reflexive questions
to ask when planning an intervention, creating a database
of reflexive practices examples, or scheduling this activity
as a recurring event.

It may also be useful to incorporate the methods and
ideas from other fields such as education, nursing and so-
cial work, which have developed empirically based ways
to foster reflexivity within the framework of Action
Research (Schön, 1983; Argyris et al., 1985; Carr and
Kemmis, 1997). Such approaches bridge the gap between
empiricism and practice, as they are often practitioner led.
The results are neither prescriptive nor quantitatively
measurable outcomes for judging the degree of criticality,
but rather practice norms that enable the maintenance of a
critical stance over time within supportive communities of
practice (McCormack and Tichen, 2006).

CONCLUSION

Even with mitigated effects, the experience presented in
this paper provides valuable insights into how an inter-
vention successfully catalysed reflexivity among health pro-
motion practitioners and the conditions that facilitated
this. Our findings point to a legitimate need to promote or-
ganizational conditions that support the development and
uptake of reflexive practices. Yet, our findings also identify
important challenges to rendering this type of practice
more ‘actionable’ within the context of ongoing organiza-
tional and funding pressures to perform. Indeed, offering
reflexive exchanges may represent a risk of disenfranchise-
ment to certain professionals. In this sense, if reflexivity is
to have a broader influence, it will have to walk a fine line
between calling assumptions into question and enabling
new ways of planning and implementing health promo-
tion interventions; in this case, by creating programmes
and policies that more effectively respond to the needs of
low SES youth.

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