

## SIMREB – towards a systematic inquiry into models for rehabilitation

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Systematic Inquiry into Models for Rehabilitation (SIMREB) is a framework for designing evaluations of rehabilitation models specifically intended for persons who are only to a limited extent regarded as being capable to speak for themselves and who, therefore, are often entrusted to a professional assessment of their needs. The article identifies the general elements in this model. By looking at both the epistemological level and the practice level from a professional as well as a user perspective the model taps into discourse analysis, institutional ethnography and a wide tradition of evaluation research. The article uses an evaluation of a rehabilitation programme for people with traumatic brain injury (TBI) as an example to illustrate the different elements of the SIMREB model.

**Keywords:** rehabilitation; evaluation; models; discourse; traumatic brain injury

### Introduction

People who are assumed not to be able to take care of their own interests are some of the most exposed people in society. Whatever they may suffer from following traumatic brain injuries (TBI), developmental disorders, mental illness or severe substance abuse, they are exposed to a professional definition of their problems and possible solutions.

Evaluators who might engage in evaluating the service offered to these people find themselves in a very ‘exposed’ and challenging position, too. The professional staff often, as was the case at Kolonien Filadelfia Rehabilitation Centre, includes highly educated and committed people who refer to a long-standing international discussion about how to organize rehabilitation and define the problems involved (Høgsbro 2002). Accordingly, they might have difficulties accepting critique which does not refer to the literature they are acquainted with. Additionally, they are practitioners who refer to years of personal experience. This was also the case in a national evaluation of training offered to children with autistic spectrum disorders (Høgsbro 2007).

However, when brought together in a new rehabilitation concept, conflicts might arise between different discourses and disciplines (Høgsbro 2002, 2007). In these instances, the professional staff sometimes need a foreign point of view, an alien profession, to mediate between the different groups, as was the case in the aforementioned evaluations.

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Furthermore, when dealing with people in an extremely weak situation, a disagreement is not only a conflict of ‘interesting’ points of view. It is a question of how to treat these people well and give them the best opportunities. In other words, it is not only a question of being a good professional; it is a question of being a ‘good’ human being. This turns any professional conflict into a complicated mixture of intellectual disagreement and personal vulnerability.

Accordingly, if evaluators want to produce a critique that influences practice, it is not enough to look at disagreements as conflicts between group interests and struggle for power within the organizational structure. It is necessary to look at conflicts as conflicts between different worldviews, approaches, and professional paradigms. In other words, it is necessary to perceive these disagreements as conflicts between different discourses or inconsistency within a predominant discourse.

In discourse analysis as well as institutional ethnography, professionals disappear as subjects of the study; leaving the scene to the study of the discourses they represent (Fairclough 1995; Smith 2005). These approaches do not question the honesty or commitment of the professionals. They address the profound dilemmas of their work: Professionals are confined by the current knowledge within their own specialized professional world, the accepted discourses and the premises that are taken for granted.

The purpose of the SIMREB model is to establish a basis for mediation between conflicting discourses which correspond with conflicts between the professionals within the staff. SIMREB provides basis for solutions to inconsistencies in the way the paradigm is transformed into practice. It is not done by hiding the conflict or placing an artificial consensus on the organization. Conflicts have to be firmly managed and evaluators have to be serious as regards the goals of the rehabilitation centres. In the end, rather helpless people are dependent on the way the professionals are doing their job at these centres.

### **Models and concepts**

The SIMREB model comprises four different levels labelled A, B, C and D and three different aspects labelled 1–3 (see Figure 1).

The A level contains the international discussion that compares results from various research traditions with ethical conceptions and political values in international agreements and manifestos. A given rehabilitation model, therefore, refers to both an international consensus on the rights of people with disabilities and the given research findings in neurology, psychology, anthropology and sociology. It also refers to culturally accepted norms for caring for others as well as pedagogical theories on how to create the best prerequisites for learning and personal development. These theories, conceptions and values lead to the development of practice. The A level determines how clients are selected for the rehabilitation programme, in that the A level defines the specific target group of the rehabilitation model.

The SIMREB evaluation focuses on identifying how the consistency between theory, concept and practice is assured by organizational means as well as education, supervision and premises for recruiting professional staff members.

The evaluator must use his or her professional skills to summarize the international discussions, isolate the basic ideas (the epistemology) of the discussion and seek out the relation between these ideas and the professional practice. The researcher uses sociological skills and techniques to investigate professional practice

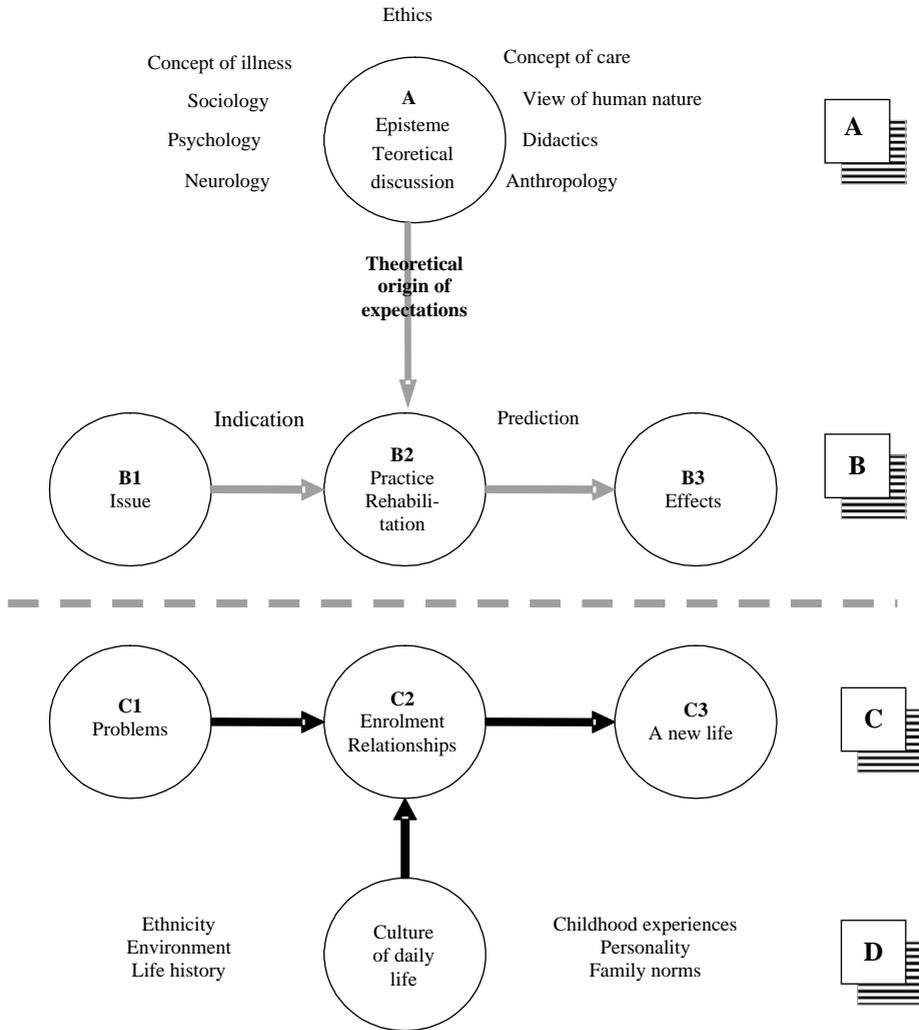


Figure 1. The SIMREB model.

and its effects. In the end the researcher presents a discussion of the consistency between level A and B and the relation between A, B, C and D as presented in Figure 1.

An important term identifies the aforementioned relation between the practitioners and the discourses they refer to. The term *discursive field* distances itself from a structuralistic social determinism and defines an approach that leaves the individual practitioner the possibility to choose between different discourses and likewise to change discourses making use of the possibilities within the field (Bourdieu 1990; Sartre 1976). The concept thus reflects the restrictions and autonomy of professional work. On the one hand social science must conceive professionals as social agents influenced by different discourses defining ‘the right way to do things’. On the other hand professionals must be conceived as creative innovative actors who ‘go shopping’ in the field of discourses, pick up suitable

elements and at times put them together in ways that might represent astonishing new ‘ways of doing or perceiving things’.

The B level contains the professional practice that is prescribed by the A level. The A level (the epistemology) defines the problems that the rehabilitation is geared towards (B1) and determines the specific type of professional practice (B2) which is regarded as relevant in each case. The A level thus determines the content of this practice in the form of methods and guidelines. Where the rehabilitation programme is expected to have a specific effect (B3), the A level defines the desired effect and how it is measured.

The C and D levels mirror the A and B levels. Thus, D corresponds to A, but from the perspective of the user. This perspective is associated with a specific culture of daily life that characterizes specific social environments, families, peer-groups, associations and subcultures. This reference framework contains its own understanding of the problems (C1), has its own expectations of relations with the professional programmes (C2) and its own requirements and expectations of the results (C3).

Many evaluations include two different types of users: people with disabilities, and their relatives. The evaluation must explicitly discuss the question of whether the professionals, the relatives and the clients understand the problem in the same way and whether the goals are the same. There might be a conflict about who is the best to define the problem, and there might be conflicts and critical points that are not discussed openly.

In a broader rehabilitation perspective, the rehabilitation ought also to include ‘community education’, e.g. the development of the community’s ability to accept and support people with disabilities (León-Carrión 1997; Sbordone 1998; Wilson 1993). Some professional models for this kind of exchange (such as psycho-educative methods within psychiatry) focus on educating parents and relatives and giving information to the milieu in which the client lives, while others focus on dialogue, empowerment and active involvement of family and friends (McNeill 1997; Patrick and Hebda 1997; Prigatano 1997). These forms of clinical intervention systematically intervene in level D, the everyday ‘common sense’ conception of the issues.

#### **A concrete case**

The following case presents some results from an evaluation of the rehabilitation work with persons suffering from TBI carried out at the Kolonien Filadelfia Rehabilitation Centre in Dianalund, Denmark, in an experimental period from 1997 to 2001 (Høgsbro 2002). The evaluation, which followed the principles of a SIMREB study, is used here with the purpose of illustrating the complicated organizational setup which confronts evaluators when evaluating rehabilitation programmes for people in an extremely vulnerable situation caused by severe cognitive and mental disturbance such as occurs in cases of TBI.

This evaluation focused on the holistic approach which characterized the Centre’s operational plan and the epistemology of the basic ideas of the original initiative which led to the opening of the Centre. The aim of this approach is to tackle the specific individual problems of the client through cross-disciplinary professional teamwork, which takes into account the specifics of the individual client’s particular background and future prospects. The evaluation was conducted as a formative evaluation (Guba and Lincoln 1989), which means that its primary aim was to

provide a feedback to the Rehabilitation Centre that could suggest appropriate adjustments and point to developmental scopes in the rehabilitation project. To do so, the evaluation had to establish a model for dealing with the epistemological questions that greatly influenced the dynamics of the professional workforce at the centre. The evaluation of organizational dynamics and development became a study of conflicting discourses and an exercise in explicating and formulating these discursive dilemmas. I have thus chosen this study to illustrate the Simreb model because it explicitly illustrates how discursive conflicts can be conceived as an important element in the dynamics of a rehabilitation programme. Other studies might be more valuable when illustrating the SIMREB approach to understanding conflicts between the professional perspective and the user perspective (Høgsbro 2007).

The 29 persons included in the rehabilitation programme during the evaluation period, had very different social backgrounds ranging from a mayor of a small city, a general manager, international consultants and skilled workers to young unskilled people who had not yet commenced their education. The brain injuries were caused by traffic accidents as well as physical abuse, individual accidents like a fall from a ladder and unprovoked cerebral haemorrhage. After the accident, the patients had been in comas for quite a long time and might have woken up without the ability to express themselves, with seriously reduced ability to see or hear, amnesia or reduced mobility. After a period some functions were regained and acute need of intensive medical treatment was diminished. At this time the patient was transferred to the Rehabilitation Centre and admitted as a client for the rehabilitation programme. Their situations and scopes for rehabilitation varied greatly at the time of transfer.

Accordingly, the rehabilitation plan for each patient was divided into a short-range and a long-range perspective. For some the ambition was to manage fundamental functions linked to personal hygiene. For others it was to eat without professional assistance, to communicate consistently by using yes/no signals and for the less disabled to keep order in clothing and daily activities. For some it was important to learn some basic social skills like being aware of how other clients might react to their behaviour. And for some it was scheduled to learn to move around in a nearby shopping centre and purchase basic everyday necessities. The basic idea of the Centre was to link these goals as closely as possible to the patients' own ambitions and expressed needs.

Thus, the rehabilitation plan referred to a dynamic relational model of understanding the interplay between body functions, activities and participation as outlined by the World Health Organization (WHO) in its recent International Classification of Function, Disability and Health (ICF) system (WHO 2001). It emphasized the patients' problems as a complex interplay between a biological trauma, personality, milieu, family background and social relations. Thus, the problems that followed a TBI could be quite difficult to define. Two examples might illustrate how this complexity opened up to ambiguities when the professionals had to decide whether they were able to help the patient or not:

- (1) One patient did not really know where he was or why. When interviewed by me, he thought he was a consultant evaluating the Centre. His speech was fluent and so convincing that I wondered whether this was really the man I had planned to interview. However, he just mirrored the social position of the person he was talking to. Most of his time at the centre, he thought he was a

- professional, helping the staff with the other patients. He only wondered why he did not receive any salary. Still the staff concluded that he was actively committed to the training and he was motivated for collaboration in his programme.
- (2) A young girl was in many ways functioning at a normal teenage-level except for some problems with walking and left arm movements. When interviewed, she, in a very reasonable way, expressed that she was bored by only spending time with middle aged people and that she longed to get home to her friends, parties and former social life. The staff regarded her as not being motivated and having no full understanding of her situation caused by a frontal lobe trauma.

These are just two examples chosen from the evaluation. They illustrate how a client's lack of cooperativeness can be interpreted either as caused by the brain injury, as caused by the milieu or as caused by the initiatives of the staff. The staff generally has to make such judgements deciding whether a person 'really' needs what he or she wants, or it is due to the malfunction of an injured brain. In this instance two epistemological references are conflicting. One refers to a *neurological* conception of motivation and the other refers to a *didactic* conception of motivation. Furthermore, the didactic conception would blame the 'school' (the Rehabilitation Centre) for not being able to motivate the client, while the neurological interpretation would blame the trauma. It is important to notice that the latter explanations might serve as an auto-poiesis, protecting the professional institution from an inconvenient and challenging critique (Luhmann 1984).

Without going into details of this case, the SIMREB model focused on the conflict between the life-world of this young girl (SIMREB level D: milieu, age-culture, personal experience etc.) and the daily routines, norms and values at the Rehabilitation Centre (SIMREB level B). Whether or not her trauma contributed to a lack of self conscience, the level of this disability would never be understood unless the staff-members took the context she referred to into consideration. Without any knowledge of her life-world, it is simply not possible to determine the degree of realism in her understanding of her situation. And the next question popping up in the mind of the evaluator would concurrently be: 'Why did the social workers at the Rehabilitation Centre not contribute to this conception of her situation?'. Further investigation into the discourse following both its diachronic and its synchronic structure (as evolved through a period from 1970 to 2004 and assimilated by the different professional groups) might explain this.

### **The epistemology of TBI rehabilitation**

In the 1970s the image of the brain changed to a 'modular' view of the brain. It became difficult to retain the image of the brain as an undifferentiated whole. The leading research milieus got more and more detailed observations of the function of the specific parts of the brain (Stringer and Cooley 2002). Later in the 1980s the image further developed when researchers began to focus on the complicated and rather inconceivable function of the frontal lobe that is obviously the most characteristic part of the human brain as it differs from the brains of other mammals (Goldberg 2001). The image of the brain now turns out to be an organization at three levels (Goldberg 2001, 58-9):

- A primary sensory projective area.
- Cortical areas which are involved in more complex information processing.
- The most complex aspects of information processing which are not linked to any single modality involving the inferior temporal cortex, inferior parietal cortex and prefrontal cortex. Together they form the frontal lobe system.

The first and the second level might be understood as following the modular principle, but the third level is different. 'The way cognition is distributed throughout the cortex is graduated and continuous, not modular and encapsulated' (Goldberg 2001, 59). Goldberg regards the frontal lobe as the conductor of the brain, mediating between the more primitive modular competences of every single part and the cultural organization of the human world. The frontal lobe entails the cultural distinction between the inner senses and sentiments and what is regarded as belonging to the outer world (Goldberg 2001, 111–12), and it is to some extent capable of using processes in one part of the brain to substitute functions of other parts of the brain (Goldberg 2001, 203). By doing this it projects its own gradual principle to the rest of the organization, and a kind of cognitive fitness becomes effective in restoring lost functions due to injuries or diseases (Goldberg 2001, 193–8). The theoretical conclusions from recent neurology and neuropsychology then lead to rehabilitation programmes that integrate the cultural context in the rehabilitation of TBI. A programme that focuses on the separate training of different functions does not restore and utilize the unique interplay between the frontal lobe, defining what actions are regarded as culturally meaningful (in respect to both planning and purpose), and the subordinated functions linked to memory, senses and movements.

This was the result of a comprehensive review of the international discussion aimed at identifying level A of the SIMREB model. It was based on a collection of articles using ordinary bibliographic databases plus a collection of references given by the managers of the Centre as well as interviews with people in key positions outside the Centre.

The introduction of the ICF system by WHO in 2001 (WHO 2001) strengthened the tendency among the professionals and officials towards focusing on the fact that various different forms of interaction are possible between the individual and his or her surroundings. Consequently, the functional level is no longer being assessed in relation to a one-dimensional scale (optimal–minimal), but takes into account the differences in context. This agenda suggests that the rehabilitation work should focus equally on developing the local context and training the patient to meet the challenges of this context. Rehabilitation becomes an affair where the goal is to 'habilitate' (as opposed to *re*-habilitation) the actual individual patient (as client) to his or her specific social context with respect to his or her personality, life-perspective, ambitions and cultural values.

From international discussions of TBI and the associated rehabilitation possibilities (at the time when the Rehabilitation Centre was being established), we could conclude that: in the last decade the functions of the brain have come to be understood as a complex interaction between a number of different systems (Boget and Marcos 1997; Roselli and Ardila 1997; Sgaramella 1997).

The central issue for the client is whether he or she can manage everyday social situations, and this social competence consists of a complicated interaction of different abilities which is linked to his or her specific individual social environment (Elsass and Kinsella 1987; Kendall 1997; Kendall, Nicholas, and Joanne 2000; León-Carrión 1997;

Machuca 1997; March 1991; Rosenbaum and Hoge 1989; Sgaramella 1997; Weddell, Oddy, and Jenkins 1980).

Technical aids provided during rehabilitation become part of what the rehabilitation aims to achieve, and clients and professionals have to pay attention to the role to be played by such aids in the client's future life (León-Carrión 1997).

The process of rehabilitation includes development of identity, self-understanding and strategies for living in a transitional situation that has the character of a crisis. This requires professional responsiveness towards the client's perspective and confidence in other professionals in the collaboration around the client (Prigatano 1997).

A client's lack of cooperativeness or lack of initiative can be due either to the brain injury or to lack of ability on the part of the professionals to create a therapeutic alliance with the client in question (Prigatano 1997).

A client's close relatives form an essential part of his or her social context – before the trauma, and also after rehabilitation. To work on the close relatives' situation is therefore a fairly important part of the rehabilitation process (McNeill 1997; Patrick and Hebda 1997; Prigatano 1997).

For the aforementioned reasons, rehabilitation cannot be limited to activities taking place in a rehabilitation centre. Rehabilitation must include an integrated effort targeted at the client's abilities in relation to coping with everyday life after the stay at the Centre and with the situation (family, home, help and support) he or she will be in after leaving the rehabilitation environment (León-Carrión 1997; Sbordone 1998; Wilson 1993).

### **From theory to practice**

When looking at the operational plan, the evaluators found that it underscored an approach primarily linked to the practice of the physio- and occupational therapists. On this basis, the other professional groups (nurses, socio-educational assistants, vocal-educational assistants and social advisers) were, according to the operational plan, expected to:

- Understand and possibly describe/delimit their own professional point of departure in the Centre's rehabilitation task and then make themselves acquainted with the main approaches;
- register the conflicts, modifications and challenges to their own established methods; and
- identify changes and professional development which is assessed to be necessary.

This introduces a kind of hierarchy between the professional groups, where the physio- and occupational therapists are expected to define the problems and the basic elements of the rehabilitation plans, and the rest of the professional groups are expected to develop their own professionalism in accordance with these plans.

At this point the international discussion seems to be paving the way for a more complex reorganization of the cross-disciplinary approach (Prigatano 1997). The cognitive problems must be understood in relation to the situation the patient comes from and is going to be living in, and consequently the therapeutic strategies must be developed with respect to the former and future conditions of the patient's everyday life (León-Carrión 1997; Sbordone 1998; Wilson 1993). The psychologists and the

social workers at the Centre should be expected to have expertise within this area. Thus, in the transformation of the discourse from level A to level B of SIMREB, the operational plan indicated that the concept had changed slightly towards a more conventional approach which was more in favour of the therapeutic professions and less in favour of including the social and psychological professions on equal terms in the planning and improvement of individual rehabilitation plans.

However, the operational plan does not always reflect the 'real' conception which dominates the professional staff. The subsequent study of the personnel's perception of the problems and their cross-disciplinary collaboration focused on whether or not this collaboration was based on a shared professional knowledge which supported the cross-disciplinary teamwork in ways which were more in touch with the international paradigm.

In the following interviews with the personnel, members of the various personnel categories were good at giving specific examples of how the other personnel groups contributed to a holistic understanding of the client's situation. In areas where members of the personnel categories expressed difficulties in relation to their integration in the project, the management seemed to be informed, which indicates a high level of communication between management and staff members. All in all, there appeared to be constructive communication among the personnel categories and between management and employees in the development of the concept.

The interviews also indicated that the personnel to some extent had a more advanced understanding of the problems than was immediately reflected in the operational plan. The cognitive problems linked to frontal lobe injuries were not regarded as diagnostically fixed characteristics, but as more dynamically linked with the conditions presented to the client and the prospects the treatment can offer. This had consequences for the way professionals looked at matters such as the client's motivation, commitment and initiative:

We have had a discussion of the fact that the neuropsychologists felt . . . that motivation is the most important thing. However, in reality the concept 'motivation' is an incredibly vague concept which is probably also built on some experience of success or the experience of something that makes a person content. And this is likewise built on knowledge of how this person achieves that feeling. . . . You can help a person by putting him/her in a situation which might strengthen and increase the motivation to take the next step. . . . However, this depends on the person in question, on the kind of problem and on how severe the injury is. (The management group)

In this interview the managers are aware of the conflict between a concept of motivation that refers to neurology, linking reduced motivation to frontal lobe injuries (a viewpoint which dominates the operational plan), and a concept of motivation that refers to didactics, linking reduced motivation to the inability of the professional 'teacher' (to make learning processes attractive by connecting them to personal life-world experiences). The latter perspective was furthermore explicitly emphasized in the following extract from an interview with one of the social workers:

A man came here in a wheelchair and he was doubtful about whether he would ever walk again. . . . His biggest goal was to be able to walk unaided. The situation was such that three months ahead his daughter was going to get married in a big church. If he had not been taken ill he would of course have walked her down the aisle, but now it was no longer possible because using the wheelchair was beneath his dignity. But still, a goal was set for him to try to reach this by training. This was very motivating for him. Everyday

he sweated and worked hard trying to reach the impossible and keep up his courage. And in three months he ended up walking on his own, and he walked his daughter down the aisle. It is important to have a goal. And he did. I believe it helped him enormously being able to look forward to that day. He even practiced in the church to see if he was up to it, because it would have been hard for him if he had had to give up and sit down realising that he could not do it. (Staff member)

The story about the man who wanted to walk his daughter down the aisle was mentioned in several interviews. It had become a narrative that confirmed the essence of the collective commitment.

Thus, the managers and the employees seemed to conceive the issues linked to TBI in accordance with international research at that time. Accordingly we had to conclude that the operational plan did not fully accredit the more 'advanced' basic concept that became visible in the interviews.

However, the interview as shown later also announced a historical conflict between the professional groups (neuropsychologists and 'others'). Some parts of the operational plan might be seen as a reminiscence of an earlier compromise between strong professional groups:

There have been some groups, who, as you know, have had some difficulties accepting the concept. In my opinion, they did not understand it properly, because, if they had understood it, I think they would have seen some marvellous possibilities in it. (The management group)

We have, in the management group, discussed if the balance between nursing and social, educational work is all right. (The management group)

So the management group did know that there had been conflicts about the concept of the rehabilitation. They also knew that some of the professionals were still questioning whether the balance between nursing, social and educational work at the Centre were consistent with the basic concept of the rehabilitation.

It was possible to identify a certain hierarchy in the authority of the personnel categories when it came to decisions. A questionnaire revealed that there were personnel categories and individuals that experienced a degree of marginalization in the cross-disciplinary daily practice (Table 1), and felt that their degree of satisfaction with the communication with the managers was comparatively low (Table 2). Furthermore, they did not feel that other personnel categories fully understood the specific strength of their own profession (Table 3). This applied particularly to the personnel categories concerned with psychological, social and educational matters.

The questionnaire indicated that there was a difference between the influence of the different professional groups, both as regards the daily decision linked to the rehabilitation of the individual client and the more general questions and strategies formed by the management. The differences seem to privilege the personnel closer to the medical professions. The hierarchy does not divide the staff into academics and non-academics, but rather leaves the social disciplines in a marginalized position compared with that of the more traditional health sector disciplines.

In the qualitative interviews this hierarchy can be recognized in the discourse about which problem is the most important. It is acknowledged at an abstract general level that the social context (recent network, competence and future perspectives) has a profound influence on motivation and the ability to cope with the disability caused by the brain injury, but when it comes to practice, the staff regards the medical,

Table 1. The staff's response to the question 'Do you feel part of the daily ADL training?' (n = 54).

Personnel category	%			Total
	To a high degree	To a lesser degree	Not at all	
Nursing aid	85.7	14.3	–	100.0
Nurses	100.0	–	–	100.0
Therapists	94.1	5.9	–	100.0
Social and psychological workers and advisors	15.4	61.5	23.1	100.0
Total	73.6	20.8	5.7	100.0

nursing problems as more convincing and indisputable problems. As a conflict between discourses it is typical that you can identify the conflict as ambivalence in the statements of all the interviewed groups:

I think that we – the social workers – have special difficulties, because here we are in a place where we have difficulties articulating what we can actually offer. We still miss communicating something and to have some methods to put on the table, saying: 'Here you are, friends'. The physiotherapists and the occupational therapists, they are really good at this. (The group of social workers)

The concept of cross-disciplinary collaboration is a fine concept, and it is one of the things I have learned at this place. Of course we understood what it was, but to put it into practice, that is something different. It is not that easy. You can have separate training, but to share the same job – to communicate your neuropsychological investigations and paradigms into a physiotherapeutic setting – demands a lot of collaboration and a lot of understanding. (The group of neuropsychologists)

Sometimes our therapists are very absorbed in their work and that is good, but at the same time we have to step in and tell them that they also have to think about the clients need for rest, too. (The group of nurses)

If you use all your energy on keeping your balance, e.g. when you are sitting up, or if you are 'piled up' with the aid of pillows and you fall across the table because you cannot keep upright then you use all your energy on that, and then there is not much energy left for training your language. So often, if people are very disabled physically, when they come we take a backseat. (The group of speech therapists)

Table 2. The experience of whether the communication between management and professionals is satisfactory (n = 54).

Personnel category	%				Total
	To a very high degree	To a high degree	To some degree	To a small degree	
Nursing aid	6.7	33.3	53.3	6.7	100.0
Nurses	–	55.6	44.4	–	100.0
Therapists	5.9	35.3	52.9	5.9	100.0
Social and psychological workers and advisors	7.7	7.7	61.5	23.1	100.0
Total	5.6	31.5	53.7	9.3	100.0

Table 3. The experience of to what degree other personnel categories understand the strengths of one's own profession ( $n = 54$ ).

Personnel category	%				Total
	To a very high degree	To a high degree	To some degree	To a small degree	
Nursing aid	–	60.0	40.0	–	100.0
Nurses	22.2	33.3	33.3	11.1	100.0
Therapists	18.8	62.5	18.8	–	100.0
Social and psychological workers and advisors	15.4	15.4	46.2	23.1	100.0
Total	13.2	45.3	34.0	7.5	100.0

It is typical for discourse analysis to find that the marginalized groups (in regards to influence/power) share and present the discourses in which their position in the collaboration is defined as less important (Fairclough 1995; Foucault 1980). In the previous quotations, we notice that the nurses actually feel rather confident in putting aside the basic philosophy of even the operational plan when 'nursing needs are self-evident'. The groups of neuropsychologists, social workers and speech therapists find it difficult to apply their knowledge to the concrete practice, to 'have some methods to put on the table, telling: Here you are, friends', like physiotherapists and occupational therapists do, and they 'take a backseat' when 'people are very disabled physically'.

This hierarchy is inconsistent with the basic epistemology of the Centre and must be regarded as reminiscence from a medical professional culture which still influences the cultural premises of the staff members.

When doing institutional ethnography, we have to acknowledge that we are addressing a front-stage and back-stage phenomenon like traditional ethnography in foreign cultures (Berreman 1962). The objective of institutional ethnography as included in the SIMREB model is not to contradict the important guidelines for carrying out formative evaluation (Guba and Lincoln 1989) or realistic evaluation (Pawson and Tilley 1997). It is still the programme theory we try to map and define, but from an ethnographic point of view we are very keen to distinguish between what people tell us they are doing, what they think they are doing and what they are 'really' doing.

### **Issues of community education and integration**

Questions about which issues are being discussed with the district authority similarly show that day-to-day activities seem to be in focus while social relations in a wider scope seem to be given less priority (Table 4). In this way a more traditional approach to brain injury rehabilitation can be jammed by the more conventional practice of local authorities.

As shown in Table 4, the assistance of the municipal case worker seems to focus on the ability to cope with domestic self-help, while social participation and support to relatives are almost ignored. In Table 5 we furthermore find that the relatives themselves do not emphasize their needs as being just as important as their ability to help the patient.

Table 4. The clients' and the relatives' assessment of which questions were discussed with the municipal case worker ( $n = 20$ ).

	No	Yes	Total
Possibilities of support for practical work in the home (e.g. cooking and cleaning)	8	8	16
Support for shopping of everyday commodities	10	6	16
Support for paperwork (e.g. correspondence, insurance policies, bills, tax forms and bank transactions)	14	2	16
Furnishing/adapting the home	9	7	16
Aids for communication	13	3	16
Continuing rehabilitation	5	11	16
Psychological support for getting used to and accepting the new situation	15	1	16
Assistance to maintain network and contact to other people	13	3	16
Assistance to go out	11	5	16
Assistance to go on outings	13	3	16
Need of connection to aid/relief assistance	8	8	16
The relatives' practical problems in connection with the client's injury	14	2	16
The relatives' psychological problems in connections with the client's injury	14	2	16
The relatives' future situation	15	1	16
The relatives' possibility of helping the client	14	2	16

According to both the ICF system and the staff members of the Rehabilitation Centre, the relatives are an important part of the context for the client, and improving their situation and clarifying their needs is thus an important part of the rehabilitation. However, the understanding of the importance of the relatives is perhaps coming up against stronger cultural premises. To institutional ethnography as well as discourse analysis it is important to notice that the client's point of view is not necessarily more 'progressive' than the professional point of view and it is not necessarily in accordance with the programme of client organizations within the field. As emphasized in the SIMREB model, clients refer to a perception of the issues generated as everyday culture in mainstream society, subcultures and milieus. These references are confronted with a professional state of art during the rehabilitation, and the possibility for a 'therapeutic alliance' between professionals and clients depends on finding a common frame of references that allows them to communicate and reach a sufficient level of consensus about what to do and how to do it.

The conclusion of the investigation of attempts to include client relatives in the rehabilitation programme thus was that what might be an advanced approach is met with difficulties when practiced in a society dominated by a much more traditional medical discourse. The relatives do not regard their own situation as important. They try to hide their problems. The local municipalities focus mainly on the biological aspects and the ability to manage daily self-help situations and they ignore questions of social relations and participation. And the professionals at the Centre 'know' that 'basic' medical problems are more 'urgent' than social problems and relations.

Table 5. The relatives' indication of own needs ( $n=24$ ).

	To a very high degree	To a high degree	To some degree	To a small degree	Not at all	Total
Knowledge of how to help my relative in the best possible way so that he/she can improve physically	11	6	3	2	1	23
Knowledge of how to help my relative in the best possible way so that he/she can improve mentally	11	4	6	0	2	23
Getting help in order for me to get as good a life as possible	8	3	4	1	6	22
Getting help in order for me to learn to cope with my feelings of, e.g., guilt, bitterness, anger or anxiety	8	3	3	2	6	22
Getting help in order for us to get the most out of our lives together	12	3	1	3	3	22

### **The response to the Centre**

The evaluation of the Centre accordingly concluded that the Rehabilitation Centre had succeeded in offering a rehabilitation process which took as its point of departure the client's own view of his or her situation. It had succeeded in making a combined professionalism available to satisfy, as much as possible, the expectations associated with the clients' prospect of the future. Relatives and clients experience a considerable degree of empathy and responsiveness (as shown in other parts of the evaluation). However, as a 'hospital-like' stay, it was still associated with considerable deference against authority. It is thus necessary that the personnel declares and outlines that openness to the client's own visions and the issues of the relatives are a necessary basis for making a successful rehabilitation plan. The Rehabilitation Centre had been somewhat powerless in respect to the development of relations between clients and between clients and relatives. This problem could perhaps be solved if personnel categories, linked to neuropsychology, social work and communication, were better integrated in the daily training (in relation both to influence and to professional development).

The total attempt to facilitate the client's integration into his or her private social contexts would of course ideally involve the concurrent development of both individual functions and of the cultural frame of reference (tolerance and understanding) of local communities (community education). This is something that the Centre's personnel has already begun to work on. However, the associated difficulties still needed to be clarified by research, and a practical solution to the problems concerning the organization and coordination of this field of work have still to be found.

### The Centre's reaction

Following up on the evaluation, the managers of the Centre announced a strategy for developing the organizational structure. It included:

- Intensifying the support to clients' relatives by offering assistance from psychologists, social workers and others with respect to the individual problems of the relatives. Furthermore, the Centre would arrange weekends for relatives where they could meet and discuss common problems and they could receive expert information about the psychological and social consequences of TBI.
- Intensifying the collaboration between the different professional groups of the staff through a reorganization of the daily teamwork. A kind of mini-team with representatives from all professional groups was organized around the individual client.
- Allocating more resources to the group of social workers at the Centre to secure a better coordination between the Centre and the local municipalities which were going to take over the responsibility for the clients' situation when discharged from the Rehabilitation Centre.

### Discussion

The SIMREB approach is to be regarded as a kind of institutional ethnography which draws upon the tradition for discourse analysis as it is developed primarily by Michel Foucault (1980), Norman Fairclough (1995) and Mitchell Dean (1999). But other sources for inspiration are brought into consideration, such as the reflections on the conflict between professional systems and peoples' life-world perspectives in the writings of Jürgen Habermas (1981), the reflection on the relation between social structures and social actors in the dialogue between Jean-Paul Sartre in his critique of Claude Levi-Strauss in *Critique of dialectical reason: Theory of practical ensembles* (Sartre 1976) and the reply to the critique by Levi-Strauss (1962) in his book *Le pensee sauvage* and the further development of this perspective in contributions of Pierre Bourdieu (1990) in his theory of practice and Clifford Geertz (1973) contribution linking structural analysis and hermeneutics. By drawing upon these discussions the SIMREB approach is able to move focus from the professionals as the prime responsible persons and focus at the limits in the recent discourses and the cultural context that confines their possibilities. As in field ethnography the professionals are conceived as informants about their own situation, as co-investigators clarifying the conditions of the field (Spradley 1979). This is an important characteristic of institutional ethnography (Smith 2005).

Sociologists often look at personal interests and group interests as explanatory factors when dealing with conflicts between different professional groups within institutions. This might of course be the case in some instances when people are struggling for influence and power. However, in many instances this approach ignores the more serious background of the conflict that has to do with the fact that the professionals are doing what they think is 'right', and what they think is right depends on the discourse they are referring to. These discourses distribute legitimate resources of influence and power between the professional groups at the institutions

in a way which is profoundly accepted by all staff members. Within discourse analysis, power and inequality among members of an organization is regarded as founded on the way people are conceiving and speaking about certain issues. The sources for power and inequality structures are thus decentralized and cannot be located to certain specific actions related to specific groups and actors (Foucault 1980).

The SIMREB design does not exclude the use of test-based summative effectiveness evaluation. This kind of effect study was included in another evaluation following the SIMREB model in its design (Høgsbro 2007). The point is only to make a critical judgement and find out when it is in accordance with: (1) the conditions for the experimental setup; and (2) the knowledge the involved actors need to gain from the evaluation. As such, SIMREB does not exclude any specific method. It is a model for understanding the professional world and choosing themes and methods that lead to practical relevant answers to questions raised by the dilemmas of the professional discourse. In the aforementioned case with which I chose to illustrate the model we were dealing with a rehabilitation programme in progress. The concept had continually developed during the first years of its existence and the managers were primarily interested in knowing whether theory and practice were in accordance. As such, the evaluation was designed as a formative evaluation and issues of effectiveness were given less priority. Furthermore, it would have been impossible to establish a control group to sustain a conventional experimental design. As such, the SIMREB model has to be regarded as a frame of reference for pragmatic solutions defining in each case what is included in the evaluation and what is left out.

One of the most crucial issues when using the SIMREB approach is how to make a sufficiently qualified review of the recent discussion within a research field the evaluator is only sporadically acquainted with in advance. It requires a certain general knowledge of paradigms within the field and it requires reliable reviews summarizing both the theoretical discussions and the results of empirical studies. But once the evaluator and his/her research institute are trained and experienced in doing these reviews you realize that though the universe of human discourses is infinite, the actual amount of different discourses is rather limited (Geertz 1973). Furthermore, the convergence between the discourses in social work and the tendency to adopt new paradigms from one field of practice into the other is rather strong. Concepts and stipulations linked to user participation, the necessity of including community education in the wider integration of people with disabilities, the focus on context and a holistic approach to disability research, including the study of biochemical factors as well as psychological and social factors, are spread between research and practice in most fields of TBI studies, studies of substance abuse, developmental disorders and mental illness in the 1990s.

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