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Svensk introduktion till den engelska artikeln

A previously tacit dimension in successful rehabilitation

av Inga-Britt Lindström, Monica Hane, Bengt-Åke Wennberg

Ett exempel på hur en ny typ av kunskapsproduktion kan avhjälpa kommunikationsbrister som skapar allvarliga samarbetssvårigheter, försämrad kvalitet, arbetsmiljöproblem och fanflykt av kvalificerade medarbetare

En reflektion av Monica Hane och Bengt-Åke Wennberg, Samarbetsdynamik AB med utgångspunkt från uppdrag gjorda för Förbundet Sveriges Arbetsterapeuter (FSA)

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Vi började fundera över allvarliga psykosociala arbetsmiljöproblem men hamnade i en ny typ av kunskapsproduktion.

I början av 2000 fick vi uppdraget att utreda varför arbetsterapeuter drabbades av så allvarliga psykosociala påfrestningar att de sade upp sig, blev sjuka eller utbrända trots att de enligt dåvarande standards hade arbetsförhållanden som borde vara de bästa tänkbara, och i varje fall inte leda till psykosocial ohälsa. Vår undersökning gav ett oväntat resultat. De psykosociala belastningarna visade sig bero på frustration.

Sjukvården är auktoritärt organiserad. Den styrs från toppen. Den är också specialiserad i stuprör efter organ och behandlingar. Patienten förväntas därför underordna sig de beslut och de åtgärder som vidtas på och mot honom eller henne av respektive behandlare. Kontakterna över stuprören är begränsade och begränsande.

Det finns emellertid i dag allt fler fall då en uppdelning på specialiteter, och därtill hörande administrativa rutiner och åtgärder, av rent behandlingstekniska skäl blir kontraproduktiva. Ett sådant tillfälle är då patienten skall rehabiliteras efter en skada eller ett ingrepp som påverkat dennes funktionsförmåga eller då patienten skall habiliteras som en följd av en medfödd funktionsnedsättning.

Den arbetsterapeutiska erfarenheten är att patienten i dessa fall måste erbjudas en möjlighet att ta sig en plats i det sociala sammanhanget. Betydelsen av att ha en funktionsnedsättning kan därmed minskas. Patienten måste således ges tillfälle att uppleva möjligheterna till en ny gemenskap och öva sin förmåga att skapa denna.

Behandlingen som arbetsterapeuten ansvarar för skall således inte bara påverka patientens fysiska funktion utan samtidigt också erbjuda denne en möjlighet att utveckla sitt sociala samspel med omvärlden. Först om patienten lyckats förvärva denna förmåga kommer funktionsnedsättningen att tappa sin laddning. Först då kan patientens övriga förmågor och förutsättningar fullt ut komma till sin rätt.

Arbetsterapeutiska interventioner passar i detta avseende dåligt in i den konventionella sjukvården. Enligt vårdens grundstruktur förutsätts att arbetsterapeuten som specialist, och i sin kontakt med patienten, skall kunna rehabilitera denne med hjälp av olika åtgärder och hjälpmedel som arbetsterapeuten själv förfogar över och kan erbjuda patienten. Detta är också så som forskning på området bedrivs och så som målet för kunskapsproduktionen formuleras. Detta blir en allvarlig begränsning.

Då emellertid samspelet, och därmed rehabiliteringen, också bestäms av omvärldens agerande kan arbetsterapeuten inte på egen hand erbjuda patienten hela den tjänst som patienten kan använda för att skapa sig en livskvalitet och fullfölja sin rehabiliteringsprocess. Arbetsterapeuten måste därför inkludera, inte bara patienten, utan också dennes omgivning, i första hand vårdsituationen och anhöriga, i rehabiliteringsprocessen.

En genomgående erfarenhet hos de arbetsterapeuter vi mötte under våra uppdrag för Förbundet Sveriges Arbetsterapeuter (FSA) var svårigheten att "komma till tals" med andra aktörer om just detta. Vården var helt enkelt genom sin organisering i stuprör inte ett lämpligt tjänsteleveranssystem för denna typ av behandlingar.

Denna brist skapade stor frustration hos arbetsterapeuterna. För dem blev det inte bara ett personligt yrkesproblem utan också ett vårdproblem, ett arbetsmiljöproblem och ett samhällsproblem. Arbetsterapeuterna hade en kunnighet som var osynlig i meningen att den inte kunde klargöras och anammas av övriga aktörer i det tjänsteleveranssystem som skulle hjälpa patienten.

Det startades därför ett projekt för att upptäcka och beskriva källan till arbetsterapeuternas frustration och ge dem själva, och deras fackförbund, en kunskapsplattform som skulle kunna göra det möjligt för dem att komma till tals med politiker, administration, anhöriga, läkare och övrig vårdpersonal om hur alla dessa kategorier var för sig kunde medverka i rehabiliteringsprocessen.

Vårt svar efter att ha utfört uppdraget var att peka på förekomsten av en individuationsprocess, det vill säga den process med vilken en människa bildar sig en identitet i samspelet med andra människor. Arbetsterapeuterna var genom sin utbildning praktiskt väl förtrogna med denna process. Det var emellertid en implicit kunskap som inte hade verbaliserats.

Frustrationen uppstod som en följd av att arbetsterapeuterna inte för andra yrkesgrupper i vården enkelt kunde förklara hur de såg på de grundläggande dimensionerna i rehabiliteringsprocessen och därmed göra individuationsprocessen till en gemensam angelägenhet. Kommunikationen mellan dem och övrig vårdpersonal om vad man gemensamt behövde göra fungerade helt enkelt inte.

Den engelska artikel i vilken vi redovisade våra studier, och där vi också redogjorde för den något annorlunda vetenskapliga metod vi använde för att finna den pusselbit som kunde åstadkomma en konstruktiv kommunikation, refuserades emellertid. Vi anser att detta beror på att man inom den konventionella forskningen varken förstod det praktiska problemets art eller behovet av nya metoder för att skapa den kunskap som skulle kunna lösa det.

A previously tacit dimension in successful rehabilitation

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Abstract

Many occupational therapists are very frustrated when they see that, given the resources available, the care offered does not aid the recovery and the rehabilitation of the patients as effectively as it might. It is often reported that occupational therapists experience great difficulties having constructive discussions with co-workers about this waste of potential. This article describes a study aimed at better understanding the source of this reported frustration. The study supplies examples of the considerations that experienced occupational therapists surely give to those cases, but which are neither obvious from a "common sense" standpoint, nor clearly expressed in the occupational therapists' case reports. The analysis shows that communicative gaps arise from describing interventions in terms of only one type of identity generating process, while in practice occupational therapists consider at least two fundamentally different processes: the process of individualization and the process of individuation. Hence, the study asserts that what has to be done clinically, in view of the tacit knowledge of occupational therapy, is considerably more complex than what generally emerges when occupational therapists present their cases to others. The findings also explain why occupational therapists have difficulties proving "scientifically" their theses and making their work methods credible through traditional controlled randomized studies.

Key words: occupational therapist paradigm, tacit knowledge, communication, ICF, work environment, frustration, individuation, individualization, rehabilitation, abduction

Background

The recovery and long term rehabilitation of patients is dependent upon constructive co-operation between the patient and the persons surrounding him or her. The Swedish Association of Occupational Therapists (Förbundet Sveriges Arbetsterapeuter, FSA) has therefore during the last decade carried out and financed a large number of focus groups in order to develop well-founded principles upon which to ground their cooperation with management, professionals, and other co-workers. These studies have shown that many occupational therapists feel very frustrated when they see that the way care is performed very often – and quite unnecessarily – limits the extent of the hoped-for recovery and rehabilitation. The studies have also shown that occupational therapists, when they see this waste of potential, have great difficulties in coming to terms about the wasted opportunities with their fellow co-workers. (1,2,3).

Regardless of the aims of the studies, the lingering feeling of frustration of not coming to terms in these matters has always been distinctly expressed. The reasons given for the frustration have usually been formulated as a question of leadership, organization, and personal relations. In order to establish a more solid foundation for such discussions it was suggested that the argumentation should be based upon actual and concrete *examples* of frustrating work situations, and that these examples then might form a more relevant basis for work environment analyses on both local and central levels. (4).

However, a difficulty arose with the practical realization of this idea. In the examples – as they were described by the occupational therapists – the communication problem was worded in terms of "the others'" lack of knowledge. However, the phrase "*lack of knowledge"* was in many cases a coded phrase meaning a lack of motivation. The "suggested measures" largely emphasized that the vocation must be given a higher status in the eyes of others. "Before that happens there is no point in trying to educate them".

In further discussions with local and central representatives of FSA, these measures were challenged as not being adequate. The implication that "the others" were lazy and ignorant was considered a very inappropriate basis for any constructive dialogue. Deeper analyses

from focus groups with other professions also indicated that the superficial (if unintended) interpretation – regarding ignorance and laziness – was highly doubtful. The other professional groups also expressed frustration about the fact that cooperation in the case of individual patients sometimes did not work. They were often left with the feeling that the measures prescribed for patients were poorly adapted to other considerations that must be made (5). The present study was carried out to seek a better understanding of the roots of the reported frustration and to make it possible to come to a common understanding.

The study emanates from the work of Professor Emeritus Håkan Törnebohm, who stated that the profession of the occupational therapist is based on a type of tacit knowledge that later has been called “knowledge in action”. (5, 6, 7, 8). Such knowledge cannot without an extensive complementary analysis be rendered into the kind of claims that others can understand and integrate with their own professional considerations. A possible source of the reported difficulties in communication could therefore be a gap between the occupational therapist’s tacit knowledge and the formal discourses that are used in the health care system.

To confirm this hypothesis, we had to illustrate the considerations that the *experienced* occupational therapist probably makes, but which are neither obvious from the standpoint of “common sense" nor clearly expressed in occupational therapists’ own case reports. The study has followed Törnebohm’s procedure – i.e. to explore the silent knowledge that the profession is based upon rather than seeking inductive or deductive proofs from data generated by traditional scientific methodology. In order to explore the silent knowledge, Törnebohm used narratives supplied by well-educated occupational therapists with extensive experience.

Hence, the purpose of the present study was to highlight such aspects of the occupational therapy practice that other professional groups, from their respective professional paradigms, might have difficulties noticing and interpreting correctly. In the worst case, these aspects are invisible and “silent” also in the narratives of frustrating situations that practicing occupational therapists present between themselves.

Material and Method

Törnebohm used a so-called abductive approach in exploring the paradigm of Occupational Therapy Practice. In the *abductive approach*, the knowledge emerges through a simultaneous interchange between three sources: established theory, actual practice, and the narratives (9). An *abductive analysis* deals in turn with trying to formulate the conditions that may be valid so as to make the problems described in the narratives comprehensible (10).

As a basis for our study we used the following five "cornerstones". Each one of them – and the procedure used to generate the data – is further elaborated in special sections below:

1. *The occupational therapy paradigm* as it is expressed in texts often referred to by occupational therapists
2. *The occupational therapy practice*, that is, the professional familiarity with the cases, the overall professional experience, and the usefulness of the new knowledge as judged by experienced occupational therapists
3. *The specific empirical material* of this study, that is, five rather extensive narratives of frustrating incidents.
4. *The abductive procedure*. The descriptions of the cases are reformulated step-by-step in order to present the narratives in a way that should make the observations and the proposed interventions comprehensible to others.
5. *Highlighting pertinent distinctions found in the tacit knowledge*, i.e., to test which theories and concepts from other fields of knowledge that can give practitioners means for perceiving and communicating formerly “silent” and invisible dimensions in the empirical material (the cases) and for imagining new alternatives for their own actions – in this case, a more exact and pregnant description of their professional considerations.

1. The Occupational Therapy Paradigm

Occupational therapy has from its start used activity/work/occupation as a means to improve health. Already during the ‘30s the doctor Jacob Billström wrote, “occupational therapy is the systematic use of work to achieve subjective or at least social health”. Work was at that time primarily regarded as a source of self-respect. It was assumed that meaningful work gave the individual the feeling of having a position in society (12). As a consequence of this historical background, the occupational therapy paradigm is associated with a social dimension that is not as evident in other health professions.

It seems, however, as if this social dimension has for decades been invisible to external observers. According to the paradigm, it is not the physical activity per se that is the central point. During its first years of introduction in Sweden, occupational therapy unfortunately came to focus on the product. This view was shared not only by the public but also by authorities and by the early occupational therapists, which at that time were nurses with a four-month course in handicrafts. As late as 2008 many people assumed that occupational therapy meant that patients would busy themselves with handicrafts as a pastime and were therefore uncertain of how this handicraft work was going to be of any help in the rehabilitation.

However, Björklund (13) and Edlund & Olausson (14) point out in their theses that the social dimension to a very high degree is incorporated in the occupational therapy paradigm, i.e. how occupational therapists according to Törnebohm (6) comprehend the world, society, and tasks. In an occupational therapy intervention it is not only the activity in itself that is important, but also the social role that the patient can play by performing it.

The international term “occupational therapy” (from the word to “occupy”) expresses more clearly than the Swedish term *arbetsterapi* (“work therapy”) that the professional paradigm emphasizes the value to the patient of occupying a position in the social environment (15). However, this aspect of the paradigm sometimes gets lost even in internal descriptions of the profession. The ethical code for occupational therapists (16) is one example. Here it is postulated “that human development depends on activity and actions”, “that man is a social being who performs actions in cooperation with others”, and “that health requires a balance between activities and rest”. Man as a social cultural individual, who lives in a symbolic universe as much as in a physical and social environment, is not referred to.

This socio-cultural dimension in the occupational therapy paradigm also has very strong indirect support in research. A large number of studies have shown e.g. that poor health and low quality of life are closely related to unemployment and feelings of alienation.

2. The Occupational Therapy Practice

The general requirements of individualization of treatment are often put forward in texts dealing with modern health care. Occupational therapy is probably even more individualized than other health care professions. The core of occupational therapy is to develop an activity that is specifically designed for the individual and based on his or her level of ability. One decidedly crucial point is whether the patient, through the activity, manages to "take a position" in the social-cultural setting in line with his/her own ambitions. The activity as such must have a positive connotation for the patient as well as for those persons surrounding him or her.

An activity, e.g. weaving, can lead to better quality of life for some patients. The same activity can, however, have the opposite effect on others. Weaving could e.g. force some patients into a “role” that he/she absolutely does not want to have (17). Hence, in occupational therapy, a key professional skill is the ability to determine which activities have good rehabilitating effect, not only by activating the patient, but also by supplying him or her with the desired “identity forming” content.

Since the suggested activities must be adapted to each patient as an individual in the context of his/her specific social situation and culture, the “interventions” cannot usefully be standardized and conveniently fit into manuals and checklists. The same activity can e.g. have totally different effects on two patients in spite of the fact that their medical diagnosis and functional status does not differ in any significant way.

Thus, the occupational therapist’s treatment cannot be evidence-based through the application of the same kinds of simple controlled and randomized studies as are used for most treatments where the same measure can be applied to all patients in the studied group. This constraint,

i.e. that the proposed activity must be selected with respect to each unique individual, critically limits the possibilities for studying the relationship between cause and effect. It seriously hampers the occupational therapist's prospects of having a say in interdisciplinary discussions regarding suggested treatments. Hence, it is particularly important that the occupational therapist be given the opportunity to explain and gain full understanding for his/her considerations in each specific case.

The difficulty involved in gaining others' understanding and approval in regard to activities and co-operative procedures also has to do with the fact that the social-cultural dimension in health care has not been sufficiently studied. The experiments in social psychology after the Second World War, e.g. Milgrams studies (18), showed beyond a doubt that human behavior and well-being is dependent upon the social role that the person gives herself in a particular situation, and upon what role she expects she might be given in the future. Experiments also show that human beings feel particularly bad when they find themselves cast in uncomfortable social roles.

These experiments within the tradition of social psychology addressed phenomena that could be elucidated only in classical experiments. The problem with such experiments is that they are unethical. For this reason, most fields of social psychology have normally been limited to exploring these phenomena through epidemiological studies. Through such studies, statistical connections can be found; but knowledge that can predict the outcome in individual cases cannot be secured (19). Therefore, occupational therapists have to a larger degree than other professions been forced to refer to so-called "tried and true experience". Due to their constant focus on the social aspect in the clinical work, this "silent" dimension has become more and more significant.

The difficulty in pinpointing this growing practical knowledge about the social dimension has appeared in e.g. work related to the International Classification of Functioning, Disability and Health (ICF) (20). The purpose of this classification code is to facilitate cooperation between the different professions that meet patients in need of rehabilitation and support. This classification is very well suited to describing activity as an important factor for the well-being and rehabilitation of the patient. However, Haglund and Henriksson (21) point out that:

The ICF might lack certain categories to describe what occupational therapists need to communicate to clients and colleagues.

Hence, there is reason to suspect that fundamental aspects of occupational therapy practice are not sufficiently articulated in communication with other professions and with the outside world.

3. The Empirical Material

During several years and in many projects with varying aims, examples have been collected from occupational therapy practice. The narratives describe situations in which experienced occupational therapists have witnessed how their suggested interventions have not received an appropriate response from other professionals and decision-makers. All these narratives form a kind of background knowledge about the phenomena that the present study addresses. A new appeal was sent out to established and highly regarded occupational therapists in order to collect even more narratives, and to gather empirical material specifically designed for this study. A specific incident was used as an illustration of the type of frustrating situation we were looking for.

The following incident was related:

> *An established musician had been invited to an old people's home. The occupational therapist intended to let some of the inmates relive the feeling of being part of a musical band, by playing in a small group in solitude together with the visiting musician.*
>
> *The staff and other inmates thought this was "unfair" and a waste of resources. Unknown to the occupational therapist, they instead organized the visit in such a way that as many inmates as possible could enjoy a moment of relaxing entertainment by the invited musician. Hence, the whole purpose of the suggested activity was nullified.*

This appeal to the selected group resulted in five new narratives. Except for the story above of the musician's visit, no more direct instructions of how to write the narratives were issued. The five narratives constitute the empirical material of this study. They were written by five different occupational therapists who voluntarily contributed with their experiences to this project.

As a part of the study, a large number of occupational therapists were then confronted with these five narratives. They certified that they recognized the types of situations, even if they have not experienced exactly the same situations in their own sectors. The empirical material of our study consequently shows how an occupational therapist normally *describes* such incidents. Nota bene: the narratives do not necessarily relate what actually happened.

The five narratives we received can therefore be said to characterize typical communicative situations that frustrate occupational therapists. The narratives, as such, also show how occupational therapists reason in these frustrating situations. It is their way of describing "the case" that is the starting point of our analysis.

4. The abductive analytical process

Established professionals confirmed that the narratives were "understood" and recognizable within the collective of occupational therapists. However, in all narratives, parts of the argumentation are missing because they are assumed to be self-evident and go without saying.

All narratives in the study were subsequently analyzed by submitting the question: "What considerations has the occupational therapist probably made, that are not clear from the verbal description that the occupational therapist presented?" The analysis concerns primarily the five narratives that define the empirical material of the study. However, corresponding analyses were also made of all the other narratives about the communicative difficulties that we have become acquainted with over the years in different conversations and studies.

The relevance of the conclusions resulting from the above analysis was then tested in several turns through giving the persons who submitted the narratives, as well as other established

occupational therapists – practicing as well as researchers – the opportunity to comment on the analyses in writing and to discuss them with us.

5. Highlighting pertinent distinctions

Part of the abductive effort is suggesting the use of established theoretical concepts borrowed from other disciplines; and testing if these concepts can offer even highly experienced professionals new alternatives in the description of their considerations. In the present study we have brought forward e.g. the concept “individuation” (22), as distinguished from ”individualization” in order to improve the discernment between the different aspects of “becoming somebody” that are manifest in the occupational therapy paradigm.

A few more concepts associated with theories of the complex development of identity (23) have also been used to highlight and differentiate between interactive processes, which are parts of the occupational therapy paradigm. The concepts that have been found relevant are persona, ipse, idem, alter and alius.

Persona is the social role you are given in a certain situation (23). Depending on the culture, all persons, patients and professionals alike, are given social roles that are based on assumptions about each other and on cultural expectations. These roles are an element of the culture and are not always constructive for the individual in question. Such established social roles are difficult to escape and they hamper communication. One way of reducing some of the negative identity generating effects, that this type of communication has, is to receive and treat the individual as a person –– not as a part of a collective or identified as a diagnosis and thereby an “object” of treatment. Another, and equally important, way to change persona is to make it possible for the person to experience that his own actions matter and that he is becoming "someone" in relation to others and in the social context.

We call the efforts to treat the patient as a unique individual *individualization* and call the process of becoming "someone" in relation to others *individuation*. It can be tempting to believe that one process follows of the other, but that is not the case. The narratives from occupational therapists tell us that efficient rehabilitation requires not only individualized interventions. The interventions must at the same time be able to support the capacity of the

patient to find a role in the social context that is realistic and possible, and which the person in question sees as desirable (17).

Liedman (23) has elaborated a description of these processes. He points out that the Latin word “ipse” conveys the thought that an individual is a special entity – separated from a collective – without necessarily being unique and unlike all others. The concept “ipse” is the fundament of individualization. The Latin word “idem” conveys the thought that individuals can resemble each other. They can have an identity very much like many others without loosing their individuality.

The thought of "ipse" makes necessary the concept of “the others”. These others can, according to Liedman, be represented with two different words: “alter” and “alius”. “Alter” symbolizes other individuals with whom I can identify – those who are like me. Through this likeness you can see yourself in others and understand how to integrate yourself in the social context. This is the fundament of individuation. “Alius” are those who are alien – and usually dangerous for me – and whom I do not understand at all.

Hence, the persona is a character role forced upon a person by social interplay; it is a mask that you put on and that hides what you believe you are, or want to become. The individual’s identity and understanding of himself and others develops through conversations and interactive patterns. “Alius” can therefore by way of different activities be transformed to “Alter”. Changing interactive patterns can transform impersonal relations into more personal relations. It is suggested in the study that this consideration of identity formation ought to be introduced in order to complement the core analysis of the “rehabilitating activities”.

Result and Discussion

Through the series of analyses of all the collected narratives illustrating the occupational therapists’ difficulties in making themselves understood, a pattern appears. It is the same pattern in spite of the fact that the examples come from different sectors of the health care

world. The hypothesis, that the occupational therapist's considerations about "activity" are based on at least two different perspectives that are not isolated from each other in communication with others concerned, receives strong support from this study. Both aspects embody the central purpose of all therapy and rehabilitation, i.e. to "become somebody".

One of these perspectives is about the importance of being seen and heard as an individual and a person. This perspective is paid much attention in Swedish health care today and is expressed through an increased emphasis on retaining focus on the patient, individualized care planning, the patient's participation in the planning of his/her care, addressing the patient by his/her first name, etc. (24). The second equally important perspective is that the patient, while feeling "seen and heard", can also "be somebody" and occupy a position in a social context.

To highlight the importance and meaning of formulating "activity" in both perspectives, we present here – as an example – one of the narratives in which this elaboration is done. In the full report, there are four more examples analyzed and reformulated in the same way as the one we present here (25). All the case reports we have analyzed within the study demonstrate the importance of describing both the individuation and the individualization process.

An Illustration of the Importance of Making a Distinction Between Individualization and Individuation

Here is the occupational therapist's original narrative about Lisa:

> *Lisa is a five-year-old girl who lives with her mother in a three-room apartment in a large town. She meets and stays with her father regularly every other weekend. Lisa has the diagnosis Cerebra Pares, which for her has led to a severe delay of her language development and a visual field loss on her right side.*
>
> *At her pre-school, Lisa has no friends among the children. She seems not to know how to play with them. If an adult invites her and some other children to play, she does rather well, but when the adult withdraws, Lisa stops playing. She has a definite*

problem with interacting socially and finding pleasure in the interaction of play with other children, and lacks experience in this. The pre-school staff sees that she wants to, but she does not know how and is afraid of failure.

She loves it, however, when an adult sits with her and reads books or plays with Barbie and Bratz dolls. Lisa is also interested in computer games and plays them with great patience. With her considerable imagination, she tells stories about the things on the computer screen. She speaks slowly and in a weak voice.

At home, the computer is Lisa's main toy, and her parents have encouraged this a lot. The parents maintain that computer games are the most important toy for 5-year-old children.

Lisa moves around passably with the help of a manual wheelchair, but has difficulty managing physical obstacles outdoors. She does not show any inclination for play or pleasure in exploring what can be done with a wheelchair so as to be able to participate in games with the other children. She can also move around by pulling herself on the floor with stretched-out legs and with the help of her arms. Her parents dislike this method of moving around and want her instead to sit in her wheelchair and on a normal chair at the table.

I therefore suggest a survey of Lisa's needs. I think it is important to find out what Lisa is interested in and wants to be able to do independently. However, the parents are not interested in any such survey. They maintain that they know best what support Lisa needs. They hope their homes will soon be adapted for wheelchairs and that Lisa will be supplied with a computer as a writing tool. They do not think any more help is needed at the moment.

I fear that there is a risk of social marginalization when Lisa for different reasons cannot take part in activities that enhance her feelings of belonging in a group or in other social circumstances.

What the occupational therapist wants to say is superficially clear from the narrative. The occupational therapist wants to highlight that Lisa for different reasons does not have the same functional abilities and opportunities for activity as other children, and that this is a problem. She also describes that the functional limitation cannot be cured or changed in a medical or biological way. Neither can it be fully compensated with physical aids. This is a clear message that cannot be misunderstood. Thus far the occupational therapist is "well understood".

However, the occupational therapist also means that the social life crisis that will be – or at least quite probably will be – a result of these circumstances needs to be mitigated through well-adapted training activities in addition to what is done today. Lisa needs to be given the opportunity to develop a self-image and to take a role in a social context that is different from the one she is presently growing into. The occupational therapist believes that she, to make such an intervention, – needs to make a more thorough examination. It is in this respect that her analysis is not "understood" and her suggestion therefore is not accepted. This is where the communication gap occurs.

There might of course be material reasons for the rejection of her proposal – but they are not the center of our analysis. Our focus is on how staff, parents and people surrounding Lisa can come to an understanding of how the occupational therapist regards Lisa's complex of problems. This is the point where the communication fails. The occupational therapist feels certain that even if she were given the opportunity to make her examination that the reactions already at this stage indicate that the persons surrounding Lisa would neither understand the value nor the meaning of the suggestions that she would arrive at. That explains the frustration.

Hence, our analysis is aimed at highlighting what is missing in the narratives where the gap occurs, i.e. in this case to make the motives for Lisa's treatment comprehensible *also outside* the occupational therapist profession. We have therefore, as illustrated in the example below, supplemented the original narratives in the study with the help of the new concepts regarding identity building, chosen from Liedman. Our elaboration of the case report about Lisa is as follows:

In occupational therapy we stress three fundamental aspects: – empathy, interaction, and activity. Empathy, i.e. the ability to see oneself in others (alter), is needed to create confidence between patient and treatment provider. From this viewpoint, it is extremely important for me to make sure that in the future, Lisa will not be regarded as an "alien" in the world around her; and equally important, Lisa should be given the opportunity to practice the skill of taking a constructive role in a social context. I can only find out how to do this through conversations with people around her – and of course with Lisa herself – about Lisa and her actions. Giving Lisa the stimulation she needs to be active is within the framework of good care. However, it is also important that we offer Lisa care that does not reinforce any possible feelings of inferiority. That could make life worse for her.

I mean that Lisa's persona – the role she is given in the social context – arises from the interactive pattern that she is currently forced into by the world around her. In this respect, the activities in her environment are now spontaneous and unplanned; for example, her parents make Lisa actively adapt to their wish for her to be "normal". In the same way her present solitary "persona" in playing is developed through the interaction with the personal assistant, the children in her playgroup and the pre-school staff.

It is true that Lisa is active and takes part in activities, but I am of the opinion that the activities are part of a very stereotyped interactive pattern, that runs the risk of being cemented. It will then produce a "persona", and also a view of her, that Lisa will have trouble freeing herself from in the future. I want the interactive patterns used in Lisa's case to be made more deliberate; I want to support her by creating interactive patterns that generate a positive self-identity in Lisa.

All the rewritten and elaborated narratives have subsequently been examined by the original authors, by other occupational therapists, by representatives from the scientific community, etc., to check whether they are –

- in accordance with the original narratives
- consistent with these professionals' understanding of similar situations, and

- in accordance with what they know from research and from so called proven practical experience

The study does not presume to explain that all instances where occupational therapists fail to gain others' understanding about their interventions have to do with the dimensions individualization and individuation. However, our hypothesis – that the communication problem often springs from not having articulated to the other person the until-now invisible dimension "individuation" – has received strong support from the study.

A New Dialectical Platform for the Profession

The study has shown that the linguistically based statements on the nature of the identity generating processes, based on Liedman's argumentation, are well worth testing as a basis for future discussions across professional boundaries. This conclusion is supported by the fact that experienced occupational therapists, when discussing the findings, report that, thanks to the study, they have "found words" for things that they formerly had difficulties expressing.

Through the analyses, potential lines of development begin to appear for strengthening the position of occupational therapy both within the health care system and in society as a whole; and at the same time for creating health care procedures that give patients better quality of life and deliver more rapid recovery.

Abduction as a Method of Making Tacit Knowledge Visible

"Statement of essence" is a concept that has been defined by the Finnish philosopher Ingmar Pörn (26). It alludes to the assumptions held by a scientist or by a profession regarding the nature of the studied phenomena. "Statements of essence" are always present and implicit in the interpretation of empirical observations, and govern the kind of logical analyses that are used. They also explain the nature of the relationships between concepts, observations and

events. They answer the questions: What is something? Why does something happen? How does something arise? When does something happen?

Inappropriate "statements of essence" give misleading answers to these questions even if the empirical material is adequately generated, correct, and relevant.

The abductive approach that has been used in the study appears to be very relevant for making visible the implicit underlying "statements of essence" that diverse professional paradigms are built on, and which can cause a lack of understanding, misinterpretations, and frustration in situations requiring cooperation. The abductive approach is therefore of great general interest for the purpose of facilitating the understanding of tacit knowledge and thereby supporting cooperation in multi-professional teams.

In many segments of society today, there is growing criticism of conventional scientific knowledge that is solely based on induction and deduction. The results are then often of limited use for practitioners and do not take tacit knowledge into account. This deficiency is well known and noticed. Abduction could be a solution to this problem (27). It is, however, still very unclear how a supplementary research strategy based on abduction could be applied to specific practical problems. This study provides an example of how this could be done.

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