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"*I Learned Nothing from Him …". Reflections on Problematic Issues with Peer Modeling in Rehabilitation.*

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Abstract

Peer learning involves processes whereby inexperienced persons learn from persons with more experience. Previous research has shown the benefit of peer learning to the rehabilitation process of people with spinal cord injuries and others using a wheelchair, yet discussions of problematic aspects are scant. Thus, the purpose of this article is to highlight two problems with peer learning. By presenting a vignette elaborated from a phenomenologically oriented case study of a wheelchair skills program at a Norwegian rehabilitation unit, the problem of a naïve view of empathy and the danger of inflicting symbolic violence are reflected upon. These reflections, though tentative, draw attention to the ethical responsibility of rehabilitation professionals who use peer learning as a part of their intervention.

Introduction: Relations of Meaning

This article starts off from some *second thoughts* that I have had concerning a research project called *Relations of meaning: A phenomenologically oriented case study of learning bodies in a rehabilitation setting* (Standal, 2009). Before spelling out these *second thoughts*, I will present relevant findings from the project and relate them to similar studies. In short, these studies will show the valuable contribution of experienced peers to newcomers in a rehabilitation process. My *second thoughts* will serve to problematize (but definitely not reject) these positive findings.

        Relations of meaning (Standal, 2009) investigated the learning that takes place between persons who take part in rehabilitation. I was not primarily interested in learning as an outcome of the professional staff's teaching, instruction, or therapeutic interventions, but was rather concerned with the learning that takes place in addition to – and sometimes even in spite of – the staff's intentions and actions. The theoretical perspectives employed in the project were partly pedagogical (i.e. the situated learning theory developed by Lave & Wenger, 1991) and partly phenomenological, in particular the work of Merleau-Ponty (1963; 1968; 2002).

        With these theoretical perspectives, I was able to show how a mutual engagement conducive to learning was established and maintained by the participants and how the on-going

negotiation of meaning in the group influenced the outcome of learning. In addition, the phenomenological approach gave insight to peer modeling (i.e. mentees' observation and imitation of more experienced peers) as a form of intercorporeal learning (see also Standal, 2011). Thus, the research project highlighted learning as an outcome of relations of meaning on two different levels: First, on the pre-reflective, where learning takes place through a transfer of body schema. Intercorporeal learning is conditioned on the meeting of two or more body-subjects who are affected by meaning (Casey, 1998; Crossley, 1996). Secondly, relations of meaning are crucial at a discursive level[1] where the meaning of the staff's instructions and therapeutic interventions where discussed and challenged by the participants. This provided the participants with a learning curriculum, which – as opposed to the teaching curriculum provided by the institutions – is the participants' negotiated response to the teaching curriculum (Lave & Wenger, 1991).

The findings from my study concur with previous research about peer learning in the rehabilitation setting and elsewhere. Carpenter (1994), for instance, examined the rehabilitation process after spinal-cord injury (SCI) in the perspectives of the individual patients. She found that newly injured patients compared themselves to, and emulated, more experienced peers. However, Carpenter also found that opportunities for peer modeling were restricted by the fact that expert peers rarely were in a position to act as such, because "there was no purpose, or inclination, for them to return to the rehabilitation setting" (p. 623). Furthermore, Ashton-Schaeffer *et al.* (2001) investigated the experience of participants in a disability sport camp for adults. The authors concluded that an environment with a mixture of novice and expert participants was conducive to learning.

Other studies have reported similar findings (McNevin, Wulf, & Carlson, 2000; May, Day, & Warren, 2006), and the conclusions are positive in the sense that experienced peers are thought to represent a valued contribution to rehabilitation in terms of providing more efficient learning situations. There is also a realization that the professional knowledge of rehabilitation staff is not sufficient for providing a complete rehabilitation service. The lived experiences of others who have gone through rehabilitation processes must be included, also within institutional contexts.

However, relations of meaning can be both good and bad: In the celebration of the valuable contribution of experienced peers, there has – at least to my knowledge – been little discussion of problematic issues with including para-professionals like peer consultants[2] into rehabilitation institutions. This was not a specific topic of my own research, but as I was working my way through to the end of the project, I began to reflect on this particular issue. I will address these *second thoughts* by reflecting on two problems with peer learning, which are identified through a vignette from the research project. I have labelled these two, interrelated problems "a naïve view of empathy" and "the danger of symbolic violence."

Context of the Study

The research took place in a naturalistic setting (Patton, 2002), that is, the author took part in an existing rehabilitation program in order to generate data by means of close observations (van Manen, 1990) and semi-structured interviews (Kvale, 1996). The particular program is called Wheels in Motion (henceforth WiM), which is a program running twice a year at a rehabilitation centre in Norway. WiM lasts for 2½ week and emphasizes the active use of wheelchairs. The

content of WiM includes adjustments and maintenance of wheelchairs, general wheelchair techniques (e.g. propulsion, getting over curbs, in and out of doors), and participation in various sports and recreational activities, like for instance basketball, dancing, and racing. The participants are people with spinal cord injuries and other impairments that require the use of a wheelchair.

WiM was initiated by a group of rehabilitation professionals who saw that wheelchair users coming to learn physical activities often did not have the basic wheelchair techniques needed to be active in their daily life, let alone take part in demanding sport activities. In addition, the participants' wheelchairs were often not particularly suited for an active lifestyle.

A peer consultant is included as part of the professional team. The peer consultant is an experienced wheelchair user, whose task is to be a model who can show the different techniques of wheelchair handling and also be a role model for the rehabilitation processes of the participants. The choice of peer consultant is based on professional judgment about how well potential candidates relate to other people and the ability to convey their experiences to others.

The peer consultant does not receive formal training by the rehabilitation professionals prior to the program. However, the professionals and the peer consultant have daily meetings throughout the WiM-program. In these meetings, they go through the plans for the day (e.g. the skills focus and selection of activities, and whether there are any participants that the peer consultant should take extra care of) and the peer consultant can report his / her experiences from the previous day. Thus, the peer consultant is sometimes given clear assignments about who to help and what to help out with. At other times, the peer consultant is present at practice sessions without having a specific task.

Each day there are 3–5 hours of training. It is individual goal setting that determines which activities each participant focuses on, and thus what each participant's weekly schedule looks like (an example of a week schedule can be obtained upon contacting the author). Those who apply to take part in the program are primarily people who have little experience using manual wheelchairs. However, also individuals with considerable experience participate. The latter apply to the program with the purpose of learning specific sports activities or starting a more active lifestyle. This means that participants are a mix of people with a lot of experience (in this study one of the participants had been using a wheelchair for 30 years) and newcomers who have been using wheelchairs for less than a year.

Method

This article draws on one vignette developed on the basis of data generated in the larger study (Standal, 2009). In this section, I will provide information about how data was generated and how the vignette was developed. The data material in the larger study consists of semi-structured interviews with 12 people: Two of these were the rehabilitation professionals in charge of running the WiM program, two of them had acted as peer consultants, and eight were participants. In order to get diverse perspective from people with different disabilities and different levels of experiences, the sampling was based on maximum variation (Patton, 2002).

In addition to semi-structured interviews, data was collected by close observations (van Manen, 1990). Close observations require that the observer takes part in the life-world of the participants, but at the same time, the observer must maintain a "hermeneutical alertness to

situations that allows us to constantly step back and reflect on the meaning of those situations" (van Manen, 1990, p. 69). At the programs I observed, I took on the role as an assistant to the rehabilitation staff. Thus, I was not watching from the sideline, but took active part in the participants' learning processes. Observations were conducted during the whole program, both during training sessions, and in more informal settings; during meals and in the participants' leisure time. Field notes were taken either during or right after observed situations.

Whereas other publications (Standal & Jespersen, 2008; Standal, 2009) from this study have analyzed and presented data by means of standard procedures for qualitative research (Kvale, 1996; Patton, 2002), this article presents the story of one of the participants through a vignette (van Manen, 1990). The vignette presented here synthesizes data from interviews and observations of one particular participant. The vignette is developed from significant episodes in the field work and the interviews that are written and re-written with the purpose of taking away all extraneous aspects of the story, so that what remains is a story that "reawakens our basic experience of the phenomenon it describes, and in such a manner that we experience the more foundational grounds of the experience" (van Manen, 1990, p. 122). This way of presenting findings does not imply that this particular vignette is a valid representation of all the stories and voices heard in the fieldwork (as if that could be possible or desirable). Rather, the vignette should give the readers an *Aha – experience*, in the sense that it pull them towards the central meaning of the lived experiences under consideration and prompt them to reflect on the meaning of that experience.[3] The following is my vignette of Turid (name changed for confidentiality) that captures her program beginnings at WiM.

Turid's Story

It is the first day of Wheels in Motion. This day is primarily used by the staff to conduct arrival-interviews in order to establish the individual goals for each participant and to perform functional tests of the participants' wheelchair skills. My role as an assistant is to be responsible for one of these tests, a sprint-test where the participants are to wheel a certain distance as fast as they can. Turid is a woman in her 50's, who has been using a wheelchair for three years following a neurological disease. She comes to the site of the test and the first thing I notice is that the air pressure in her tires is far too low. The pressure is 2 *bar* while the standard for the test is 9. In addition the chair is dusty and dirty. I then told her that it is an advantage to have sufficient air pressure in the tires, because the chair will roll better and that by keeping the chair clean and properly oiled it will improve its functionality. She responds to me that she has not cared to maintain the chair, because she is angry at it. "It is not a part of me," she says, so she has kept it in a state of disrepair.

As I got to know Turid further, I understood that she had difficulties handling her situation after the illness. She told me that she avoided going out in public places, and that she was hesitant towards participating in the program: "I'm over 50 years old, so I was a little surprised that I was admitted to the wheelchair program…. you know I was afraid that I was going to be sitting here and be the one who didn't dare anything and who didn't manage things." Despite her lack of confidence in her own skills, Turid did well on most tests as compared to the other participants. Yet, the sorrow she felt over her new situation and her lack of confidence were aspects of her way of being that came up quite often in our conversations during the program.

Turid's relation to the peer consultant, Kari, turned out to be of significance. Kari, who was a woman in her mid 30's, was the peer consultant in the WiM program where Turid participated. At the time of the study Kari was aspiring for Paralympic participation, so her skill level could be described as high. Yet, she was not able to perform some of the skills that particularly strong men with lower SCIs can do. However, one of the interesting aspects of her way of relating to the participants was that she oftentimes told the other participants about her fears and worries.

In an interview Turid recalls one such situation: "I feel that the peer consultant is important because she is Kari, and she has climbed the same steps that we are climbing. Like the other day somebody said 'This thing about going to stores, that's not a problem, really. You just shouldn't feel [that it is difficult]. It is just to keep your head high.' But then Kari said that she had felt that going to stores was difficult, and she still feels that way, so she has kind of seen it from our side. . . . With her whole way of being, she has in a sense taught me a lot."

Later in the interview, Turid contrasted her experience with Kari with another peer consultant she had met at a different rehabilitation institution: "There [names the institution] we had this guy with cerebral palsy who was super good in the wheelchair. I learned nothing from him, because he just came to show off his tricks. I got the feeling that he was kind of too good and too little – I don't know – I think he saw himself as being in a class above us."

Discussion

The vignette about Turid will serve as a backdrop for the reflections on two problems with peer modeling. But before doing so, a couple of comments on the vignette are in order: Firstly, not all participants reacted positively to Kari's openness about her fears or worries. Some participants indicated that she was not a good peer model precisely for this reason. This disagreement underscores the importance of understanding the divergent perspectives of participants who learn together in groups.

Secondly, the vignette highlights a point made in other studies on peer modeling, namely that being shown a skill by people who themselves are dependent on wheelchairs is conducive to the newcomers' learning process (Bandura, 1986; Carpenter, 1994). The credibility of a peer model is considered to be higher than when a non-disabled professional shows the same skill. However, as research also shows, this does not mean that learners will discard instructions and demonstrations provided by people who are non-disabled (Bandura, 1986).

The Problem with a Naïve Conception of Empathy

The reasons for including a peer consultant in the WiM program was that the professionals organizing it, realized that it would be better to have a person with a disability to both show the skills needed to be learned, and to be a model for the wider process of rehabilitation. Both the professionals and the participants in the study underscored that a positive aspect of the program was that it included an instructor who had lived through the rehabilitation process herself.

However, the vignette also shows that having a disability is no guarantee for establishing a successful learning relationship between the peer model and the mentee. Turid told us about the person who was "super good," but from whom she did not learn anything. Peer modeling is not

facilitated simply by the basic fact that the model and mentee have similar disabilities. Such an assumption rests on a naïve notion of empathy that needs to be discussed.

The work of Toombs (1992) provides a useful starting point for this discussion. Toombs investigates the different perspectives of doctors and patients, and argues that it is not primarily different levels of knowledge that make these two perspectives different. Rather, the difference is grounded at a more basic level, namely in the difference between meanings as constituted in direct, lived experience (patient) and through scientific knowledge of disease states (doctor).

Toombs (1992) shows how illness and disability are constituted in the experience of the patient and how this experience is radically different from the doctors' scientific understanding of the patient's illness. In order to describe the sources of the different perspectives of doctor and patient, Toombs explores the way the body is perceived by these two groups. One of the fundamental causes for the different perspective lies in the experience of the body: For the patient, the body is lived, and the lived body in illness and disability has different experiential properties than the body-as-scientific object, which is the perspective of the doctor.[4]

For Toombs (2001), empathy is a basic mode of consciousness in which one can imaginatively project oneself into the other person's situation. With regard to her interest in the doctor – patient relationship, she argues that by an act of imagination it is possible to bridge the gap between doctors' and patients' different lifeworlds. Toombs suggests that the exercise of imagination, which is necessary in the doctor-patient relation, is not required in the meeting between patients who share similar lived experiences. At least, it is not required to the same degree, because people with disabilities share a mutual and empathic understanding of how the body is given and experienced in disability:

> those who have been sick share an empathic understanding of the "givenness" of illness in that they have a mutual understanding of the manner in which the body is apprehended in illness – as an oppositional force, a physical encumbrance, as that which is "uncanny," and so forth. Consequently sick persons can share something of another's experience of illness regardless of the disease state and without the need for any physiological explanation. (Toombs, 1992, p.98)

However, empathy is not guaranteed simply by sharing somewhat similar disabilities: "Seeing the other's situation 'through one's own eyes' from within the context of one's own value system is more likely to hinder empathic understanding" (Toombs, 2001, p. 258). Thus, empathy is more a matter of trying to grasp what it is like for the other to be in that particular situation. This means that seeing empathy as an unproblematic process of mirroring the other, for instance that the peer model understands the other participants just on the basis of the fact that they have similar disabilities, is problematic because it ignores the myriad of other ways that people differ from each other. The disability is but one of many attributes of a peer model. In addition she/he has a gender, an occupation, a social background, and a unique biographical life history. There is just no guarantee that two persons – even if they have close to identical impairments – share the same value system.

What is needed is that the peer model is in possession of an ability to understand the meaning of disability as it is lived and experienced by the mentee. This requires, according to Toombs (2001), an imaginative self-transposal, which is an attempt at seeing the world through the other's eyes. The nature and extent of this imaginative self-transposal can be debated (Smith, 2008), but an ability to transcend one's own perspective and one's value system is in some form

needed for empathic understanding to arise. In the concrete case under consideration here, Turid's embodied experience of breakdown, in a sense projected onto the chair by way of its falling apart, is shared and recognized by one peer consultant (Kari), but not by the other (the "super good" guy).

The Problem with Symbolic Violence

Turid regarded her relation to Kari as a positive one. She did not only emulate Kari's skills and techniques: As Turid points out, Kari's "whole way of being" was important for her learning process. In the context of peer modeling, this suggests that observation and imitation is not a technical or straight forward process of imitating and trying out a behaviour displayed by the other. It is closely tied to the lived relationality between model and mentee. The relations that are formed and maintained between peer models and mentees in situations where skills are learned transcend a narrow focus on technique and the right way of performing the skill. It also embraces the peer model's way of being, that is, it is also related to being and becoming someone (Nielsen & Kvale, 1999). On the other hand, Turid also talked about the "super good" peer model she had met at a different occasion than the WiM program. The relation between Turid, and that person, could be characterized as an example of failed empathic understanding. In terms of being a good peer model – and here we must take good in the ethical sense of the word – this other person mentioned by Turid was seemingly unable to convert his abilities into a good learning situation for Turid.

The encounter described by Turid also contains more than failed empathy and lack of learning. It could also be seen as an instance of symbolic violence. This term is defined as "the subtle imposition of systems of meaning that legitimize and thus solidify structures of inequality" (Wacquant, 2006, p. 20). In the present context, symbolic violence is the conduct of setting up a normative symbol for what the participants can become, when as such a symbol is perceived to be unattainable by the participants. Importantly, the imposition of symbolic violence takes place in subtle ways, more like under communicated and indirect texts rather than something said directly and unequivocally.

Turid's case exemplifies this succinctly: When she talks about the peer model that was "super good," Turid clearly sees this person as someone who is on a different and – importantly – unattainable level for her. One might of course ask why this person was recruited as a peer model. A possible reason could be that he, as a person who seemingly did extraordinary well, was thought to serve as an example of what is actually possible to attain; i.e. that showing his (so-called) successful rehabilitation could serve as an encouragement for newcomers.

Whether this was the reason or not, the peer model was sanctioned and authorized by the professionals at the institution. He was recruited and given the opportunity to return to the rehabilitation setting in order to be a peer model. As such, he serves as a normative symbol for the mentees in the sense that through him, the rehabilitation professionals imply "this is what you should aim at – this is what you should become like."

Frank (2004) discusses the issue of symbolic violence with regard to learning and medical situations. He points out that when people seek a cure for their illness or want to learn something, they come because there is something desirable that they presently lack, and that they cannot (easily at least) attain on their own. As learners, we are in relationships where we are dependent on others. People like Turid and others who come to rehabilitation institutions to learn

wheelchair skills do so because they see a need for them to learn these skills and because they are not able to learn the skills by themselves. Thus, both rehabilitation professionals and peer models attain a sense of authority because they are in a position to provide patients with their expertise and knowledge.

In position as experts, both professionals and peer models, are therefore continually at risk of inflicting symbolic violence: They may see the clients' lacks and needs, but then move too quickly to providing a solution to the clients' perceived needs:

> It thus becomes all too easy for professionals to forget that people also want to be respected for who they already are. The professional finds it too easy to see the client's need or lack, [and] move to some solution or remedy for that. (Frank, 2004, p. 116)

What Frank highlights here, and which was also pointed out through Turid's case story, is the danger of providing solutions to problems too fast without considering the individuality of the persons they are supposed to help.

Closing

By contrasting two experiences that Turid has had with peer modeling – one good, in which her struggles and difficulties where acknowledged, and one unsuccessful, in which she "learned nothing" – I have tried to bring out two problematic issues with peer modeling, namely problems concerning empathy and symbolic violence.

Rehabilitation is in some quarters considered an oppressive, normalizing effort performed by a disablist society (Grue & Heiberg, 2006; Paterson & Hughes, 1999; Seymour, 1998). One way to improve the rehabilitation services could be to include people with disabilities as (para-) professionals. The inclusion of peer learning in rehabilitation practice comes from a realization that an expert system where non-disabled professionals tell patients how to improve their skills and how to live their lives is not sufficient. Research has shown that in terms of learning skills and getting a sense of the broader picture of living with a disability, peer models are beneficial. But the above considerations also suggest that peer modeling is not a straight forward and unproblematic process. What I have pointed out in this article is that also people with disabilities can be complicit in oppression of the lived experiences of other people with disabilities. Sharing similar forms of impairment is not a sufficient requirement in order to act as peer model. Neither is it sufficient to be highly skilled and coping well with life as a person with a disability.

This means that whenever we devise (learning) strategies in rehabilitation, we must begin by being oriented towards the unique lived experiences of the individual participant. This sentiment, expressed by Connolly and Craig (2002), urge us to think of rehabilitation as "a credible place from which to devise strategies for actual bodies to dwell in the world in honorable ways" (p. 455). Thus we have entered an ethical landscape where the question of how to meet the other becomes pressing. In this article, I have only presented some tentative thoughts on this issue; so further research concerning the ethics of peer learning is warranted. Another implication is that rehabilitation professionals, who are responsible for the recruitment and supervision of those who are going to serve as peer models, have an ethical responsibility towards the participants who are exposed to peer consultants.

In the text, I have used the word *problems* deliberately, because I do not see the issues identified here as *challenges* that can be addressed and solved once and for all. Rather, they are issues that should continually trouble, worry, and unsettle practitioners and researchers alike. All this should of course not be interpreted to mean that peer modeling should be abandoned. The positive contributions made by peer consultants are not to be underestimated, and can complement the professional expertise of rehabilitation staff. However, the potential problems pointed out in this article pose great responsibility on the rehabilitation professionals. A peer model should not just be good in the sense of being skilled, but she/he should also be good in the ethical sense of the word.

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Endnotes

[1] The relations between pre-reflective experience and meaning constructed at a discursive level are complex. Here, I only want to make clear that I do not hold that these are two distinct and discrete levels, i.e. that pre-reflective experiences are first made (or had) and then later given meaning in propositional language.

[2] In this text, I will use the notion "peer consultant" for a person who is included in a rehabilitation program with the specific purpose of being a peer model, i.e. a para-professional. A peer model, on the other hand, is a person who is imitated by another. As shown in my research, the peer consultant is not always considered by participants as a good or useful peer model, and any participant can function as peer model for other participants, without this being intended (or wanted) by the professional staff. Peer learning is the term I use for the broader process whereby an inexperienced person learns from a more experienced one.

[3] The project was given the necessary ethical approval before it started, and needless to say, the names used in the text are fictive ones.

[4] This difference in perspective between patient and professional is one of the important reasons for including a peer consultant into the WiM program.

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