



Mutual Influence between Rehabilitation and Psychoanalysis

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Abstract

The psychoanalytic and rehabilitation therapeutic perspectives maintain different professional approaches and points of view, uphold independent concepts and clinical tools, and rarely encourage professional dialogue between the two. Yet, a review of the deep changes that have taken place within each of these approaches over the past two decades provides a foundation to argue that both of these approaches are in fact mutually enriching, and can lead to potentially useful conceptual and technical development. The implications of these developments for theory and practice are discussed.

Introduction

This paper argues that two seemingly contradictory theoretical perspectives, that of psychoanalysis and that of psychiatric rehabilitation – are in fact more similar than first meets the eye. Moreover, they are likely to be of mutual influence to each other, as opposed to rejecting of one another. The parallels between these two schools of thought are becoming more apparent following the developments over the last two decades both in terms of their conceptualization as well as their theoretical insights. Such resemblance is surprising in light of some of the clear seemingly structural differences between them. The purpose of this paper is to discuss some of these inherent differences as well as parallel developments and discuss their implications for theory and practice.

Discussing the similarities

To begin with, the two disciplines traditionally target different populations: psychoanalytic therapy is tailored primarily for those suffering from anxiety and depression – disorders considered to be in the lighter end of the psychiatric disorders spectrum, while psychiatric rehabilitation targets those who are experiencing more severe psychiatric disorders, such as schizophrenia spectrum disorders. This distinction in the target population has led to some of the differences seen in the intervention perspectives and practice, which characterize each of these disciplines. For example, one such difference refers to the figures involved in the therapeutic process. Psychiatric rehabilitation often engages numerous bodies, such as health and welfare agencies, to contribute to the process; whereas psychotherapeutic psychoanalysis rarely relies on other figures aside from the therapist. On the one hand, the involvement of such bodies is likely to help identify and target various domains of needs, and in the achievement of a comprehensive and wide-ranging intervention. Yet, on the other hand, it is also likely to undermine and jeopardize the stable and clear alliance achieved between the practitioner and client.

A further distinction between the two disciplines, which is also portrayed in their practice, lies in the way in which practitioners act to maintain their own personal boundaries. Maintaining personal boundaries is important to the practitioner in order to be able to give reliable meaning both to their own and to their clients' intra-personal reactions and processes. Maintaining boundaries helps avoid projections and wrongful attributions of motives, emotions and behaviors upon the other, instead of taking responsibility upon oneself; or avoid the contrary of taking too much responsibility upon oneself and thus eliciting feelings of guilt or shifting the focus from the client. Thus, the accurate maintaining of personal boundaries during the

process helps clinicians better identify their own needs and interests and separate them from those of the significant others around them. However, the actual task of maintaining such boundaries differs for therapists from each of the two therapeutic approaches.

For the rehabilitation practitioner, the difficulty to maintain such boundaries might be related to the lack of a distinct space defining the therapeutic environment. In rehabilitation, the characteristics of the client's illness and disability, the social setting and the physical structure of the rehabilitation and therapeutic surroundings, can easily challenge the boundaries between the client and practitioner. There is often no set context, such as a clinic or an office, and the setting is often dictated by the emotional and physical functioning of the client at the time, as well as by further activities in which he/she is expected to take part. In this way, the interactions often demand different social and behavioral interactions. These varying structural challenges often challenge the task of identifying and defining personal boundaries.

For psychoanalytic therapists, on the other hand, the difficulty in maintaining personal boundaries arises from a different source. In such a therapeutic relationship there is likely to be a greater resemblance than in psychiatric rehabilitation between the therapist's own issues to those of the client's. The level of personality organization as well as the social and professional functioning of the parties involved in the psychoanalytic therapeutic relationship are often similar, making it difficult for therapists to identify and maintain the personal boundaries between themselves and their client. This, in turn, may lead to the mistaken identification of the reasons behind interpersonal issues, emotion and motive.

The need to clearly define the boundaries between client and therapist, and to help the client recognize his or her own boundaries, have been identified as aims for all forms of mental health treatment. Yet, the different challenges that each therapeutic technique faces in achieving these aims lead to differing needs and focal points, and thus

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distinct therapeutic processes. In this way, the practice of rehabilitation and psychoanalytic disciplines is also divergent.

Thus, so far, a number of profound differences have been named between psychoanalytic and psychiatric rehabilitation, including differences in the target population, the clients' grievances and some issues concerning the practice, conceptualization, and terminology formed by each discipline. Focusing on these differences is likely to lead to the conclusion that these two disciplines can be referred to as discrete aid professions that have little in common.

Indeed, such differences in terminology and practice have led to the perception that each belongs to completely independent fields, with its own distinct rules and regulations. For example, one such rule in the field of psychoanalysis is that therapists themselves must go through therapy in order to deal with their own issues prior to treating others. They are expected to solve or, at least, seriously examine the inner conflicts that drive their behavior, either consciously or unconsciously, in the same way that their clients will be expected to. Yet, it is hard to imagine a similar guideline for those working with people who have a serious mental illness.

The differences between the two perspectives have contributed to the fact that there were very few attempts within the professional literature to explore the common ground between them, something which could, in fact, enable mutual clinical and theoretical enrichment. This is further enhanced by the lack of joint professional conferences, the separate publication of clinical research in independent journals, the absence of cross-referencing of each others' work, and the fact that experimental forums do not facilitate the presentation of joint and cross-disciplinary research. In this article we shall argue that, paradoxically, there have been surprising and fascinating theoretical and clinical developments over the past decades that have in fact brought these two disciplines closer together. Both experimental research and conceptual advances have led to this convergence, which is, therefore, of importance and interest.

Thus, we shall now turn to the central purpose of this article: the evaluation of the similarities that exist between psychoanalysis and rehabilitation psychology, similarities that have come about from the clinical and theoretical development of each of these disciplines.

Parallels in the development of psychoanalytic and rehabilitation perspectives

Psychoanalytic theory is going through significant changes in its definitions of healthy and pathological human development, in its aims for therapeutic intervention, and the essence it assigns to therapeutic change [1-3], (Fosshaghe, 1881); [4]. These developments, which have not occurred without professional and ideological dispute, reflect wider social and cultural change often categorized as "post-modernism". These changes can be seen, for example, in the more mutual therapeutic relations between client and therapist than those that were once acceptable by psychoanalysts. Alongside these shifts in perspective, important changes are also occurring in psychiatric rehabilitation - in its aims and in its form of practice. These changes are characterized by a late recognition of the central role of mental health consumers in their recovery process. [5] (Deegan, 1993).

By analyzing and reviewing some of the major changes in the conceptualization and practice of these two disciplines, it can be seen that psychoanalysis and psychiatric rehabilitation converge. We shall now point to some of the areas in which this can be observed:

The relativity of perceptual truth

Developments in psychoanalytic theory: In the past it has been argued that every experienced psychoanalytic therapist that has resolved his or her own neurotic problems will identify the same elements and conflicts in the therapeutic material he or she observes as other therapists of their kind (positivism). However, due to the growing recognition of the ambiguity of personal experience and its constructed nature it has become apparent that the assessment of therapeutic material, such as the client's experiences, the interaction between client and therapist, the client's free associations, and so forth, all receive different interpretations by different therapists, regardless of how experienced they are (Relativism) [6,7]. It has also become apparent that observers, merely in their presence within the 'field' in which they are observing, change that field and thus the outcome of their observation [8]. Thus it is clear to therapists today that instead of knowing the truth about the client, they know only one truth of many.

Developments in psychiatric rehabilitation

The rehabilitation field has also seen changes in its perception of the "truth" with regards to the clients' circumstances, as seen, for example, in the term "insight" regarding the persons' illness. If in the past the level of clients' "insight" was evaluated as their level of "acceptance" of the illness, as identified and defined by the psychiatrist, nowadays "insight" is a multi-dimensional concept [9]. It is more widely accepted that "insight" has a broader variety of meanings, reflected in the different ways in which the clients' disorder can be understood [10]. In other words, there has been a change from emphasizing a single "truth", defined and determined by the practitioner alone, to accepting a variety of truths for understanding and defining the disorder. In this way, there is widening legitimization for the existence of differing points of view, and "insight" is no longer seen as essential in the strive for real change.

In this way, it seems that both in psychoanalytic literature and in that of psychiatric rehabilitation there has been a shift from the positivist model to a relativist one.

The emphasis of subjectivity

Developments in Psychoanalytic Theory: Within psychoanalytic theory, there has been a significant shift in the therapist's position, from an attempt to reach an objective perspective to the acceptance of subjectivity in both participants of the therapeutic relationship [11,12]. By definition, it has become clearer to therapists that they are unable to hold an objective-reflective position, like a surgeon without feelings towards their client and treatment material, as Freud had once maintained. With time, it began to be argued that the therapist's feelings and responses, as defined by 'counter-transference', provide important information regarding the client's experience. However, it was still recommended for therapists to rid of these feelings, in order to enable them to provide full attention to the material brought by the client and the therapeutic aims. Today it has become more widely accepted that therapists are not only unable to keep their feelings out of the therapeutic setting, but, moreover, that these feelings are likely to be of significant value to the understanding of the client's experience and distress and understand his or her communications.

Similarly, therapists also began to accept that they bring their own subjectivity into the therapeutic encounter. Such subjectivity includes the therapist's own theories, beliefs, commitments, experiences, morals, and gender biases. As professional acknowledgement for

the view that therapy is a meeting point between two subjectivities increased, the need for therapists to openly struggle with the expression of their subjectivity decreased. Moreover, therapists began to use their own subjectivity by striving to reach a thorough understanding of the inter-subjective field within the therapeutic setting and thus helping clients identify their own contribution to this field (and to their wider experiences, in general). The perception of therapy as an inter-subjective field has, thus, brought with it the view that the interaction between therapist and client is jointly determined by the dynamics and the needs of both. This argument leads many to believe that any understanding of psychopathological manifestation without its interpersonal and inter-subjective context: including that of the therapeutic environment, is meaningless [13].

Developments in rehabilitation psychology

A similar shift - from trying to maintain objectivity to seeing the benefit and value of subjectivity - has also been noted within the psychiatric rehabilitation field [14]. It is particularly noted through the criticism given to the supposedly objective position maintained by biological and psychiatric theories.

These two disciplines, biological and psychiatric, both aim to reach scientific grounding by only using valid and reliable observations methods and arguments that can be tested empirically. Yet, it shall be argued herein, that although the biological and descriptive approaches have significantly contributed to the field of mental health - for example, through the categorization of psychological disorders, identification of treatment, formation of reliable concepts, and the improvement of the communication between therapists and professionals - they carry with them disadvantages and limitations [15]. By scrutinizing these perspectives, it will be possible to show how they prevent, or at least delay the ability to assess important and valid symptoms and manifestations, that are hard to evaluate empirically. For example, the third and fourth editions of the DSM categorize disorders phenomenologically, i.e. according to what can be observed and measured reliably. Thus, a phenomenon that is difficult to assess reliably, such as the personal healing process and the subjective quality of life, are not included within the DSM despite its great importance. In this way, manifestations of personal distress, hopefulness and further significant factors are neglected, factors that may be of help in the professional work of mental health providers.

In this way, it is possible to see similarities in the development of both psychoanalytic and psychiatric rehabilitation literature: both have moved away from an objective perspective and attribute greater importance to the subjective experience.

The importance of the relationship and relational patterns

Developments in Psychoanalytic Theory: Further changes that have taken place within psychoanalytic theory relate to a new understanding of human motivation and behavior. There has been a change, from emphasizing the influence of psychological drives that originate biologically, as had originally been suggested by Freud, to emphasizing relational patterns and the role of inter-subjective mutual influence as motivational factors [16,17].

Classical psychoanalysis saw human motivation as based on needs that are a psychological expression of biological drives, conveyed through desires, wishes and fantasies. Every emotional and behavioral response is thought to originate from the need to either release these drives, or to fight them and thus avoid their overt and conscious

expression. Thus, according to the classical theory, drives are what primarily shape interpersonal relationships.

Today, the quality of primary relational patterns, characterizing interactions with significant others of close proximity in the first years of life, are seen as shaping human motivation. Thus, drive derivatives which are expressed in wishes are determined by the quality and form of imprinted primary relationships. These relational patterns are conceived as the building blocks of the growing personality within human development. Relational patterns are seen by theorists and clinicians as reenacted throughout life, and thus as shaping the experience of the present, alongside with the influence of specific inter-personal contexts. All these cause therapists today to ask which relationships encourage growth and which inhibit it, instead of asking the classic question of what intra-psychic schemas motivate their clients.

Developments in rehabilitation psychology

In psychiatric rehabilitation there has been similar development in the understanding of the central role played by relations, as can be seen by the therapeutic importance attributed to self-help groups and to services provided by other clients [18,19]. Indeed, there is an increased understanding that clients feel more comfortable and understood by others who have gone through similar experiences to them, and it seems clearer that the most active and important element in the success of rehabilitation lies in the relationships a client forms, and not the use of therapeutic technique or skill.

Moreover, first person accounts suggest that clients identify the presence of someone who believed in them and in their ability to recover as the central factor in their recovery (Deegan, 1998; 1993). This significance assigned to the existence of such a person/people in the client's life, further demonstrates the great importance relations play in the rehabilitation process.

Thus, in similar ways, the two disciplines raise the value of relations as an area for research and as an important therapeutic tool which they dedicate much effort and resources to.

Personal experience as the source of knowledge in therapy

Developments in Psychoanalytic Theory: Currently there is an epistemological change [20-21], in the opinion that meaning from clinical and therapeutic findings in human-sciences cannot be derived in the same way as it can be in natural-sciences through the registration of events in the physical field. While in natural-sciences it is possible to isolate variables in a laboratory and to assess and evaluate them in a clean empirical manner, in human-science a reasonable method in which to attach meaning to personal and inter-personal events and processes is through personal interpretation. The scientific hermeneutic position, which was developed for the research of Holy Scriptures and implemented in the work of psychoanalysis, argues that every piece of information that is received by the therapist from the client, is assessed and assigned a meaning in light of the context in which it appears. The context is then given further meaning by weaving together more and more pieces of information are noted. As this web of information deepens and widens, so does the understanding of the context in which new material is provided, which in turn, influences the meaning that is attributed to further new observations.

Following on from here, it seems that in therapy the way in which to get to know the client and the intra- and inter-personal processes that characterize him/her, is unique and personal to the person wishing to

do so. This process does not rely on solid “facts” that can be quantified or empirically and objectively determined. It is a journey that relies on careful, meticulous and personal attribution of meaning, a process which is audaciously related to the subjectivity of the observer.

This transformation, in the recognition of the source for knowledge in therapy, is still to change in the delineation of therapeutic goals. A tendency to emphasize the therapeutic relationship as the central curative cause, instead of “objective” interpretations assigning causal explanations to clients’ concerns and dynamics, has developed [22], (Bucci, 2000). The therapeutic relationship is seen today as the relational frame within which it is possible to relive deep fundamental experiences that had been experienced as traumatic or deficient as well as yearnings in the distant past, in order to reorganize them differently - openly and more flexibly. In this way, the therapeutic relationship is seen as compensatory for early developmental deprivation and damage, while interpretation is seen as a way to express empathy, to be close the client’s experiences, and as a way to strengthen the therapeutic relationship. The therapist, therefore, needs to identify the setting which shall allow optimal psychological growth for each client, so that each can find the way to develop and grow in those areas where his/her development was prevented.

Developments in psychiatric rehabilitation: Today, psychiatric rehabilitation shows increased awareness for the need of therapeutic aims not to be defined according to speculation about the clients’ developmental deprivations that may have led to their current problem. The deprivation that is viewed as relevant and significant are those that have hindered the person’s opportunity to become a valued member within his or her community of choice, build a sense of autonomy, and define a sense of self as an initiator and implementer of one’s own self defined goals (Corrigan et al., 2006).

This estrangement from speculation regarding the source of the person’s present distress, has led to, amongst other things, the increased prominence of the narrative psychology discipline in the past few decades. At the base of narrative psychology theory lies the argument that historical truth is not necessarily more important than the personal story. On the contrary: the personal life story determines the “facts”. In other words, the facts are constructed by the narrative and exist according to and because of those who experience or describe them to themselves as well as to others [23,24]. This theory encouraged the practitioner to learn about and draw nearer to the subjective and personal experience of the person coping with the disorder. According to this theory, a personal life story exposes and expresses the identity of the story-tellers through the meaning that he or she assigns to their life and the events they experience and describe in it. At the same time, the story is a means through which a personal self identity is formed and strengthened further influencing events that develop in their future life (Roe et al., 2010; Yanos et al., in press).

In other words, the similarities in the development of the two disciplines can also be seen here, in that both express increasing interest and acceptance of subjectivity as a critical source of knowledge in the definition of personal goals and life aims.

Emphasizing interpersonal contexts

Developments in Psychoanalytic Theory: The aim of the classical psychoanalytic therapeutic technique was to facilitate the necessary environment allowing clients to project their internal world of conflicts, wishes and fantasies onto the therapist (Aron,1996),[25]. These projections were thought to mark and define consistent tendencies,

characteristics and intra-psychic structures within the client. They were considered stable, beyond temporary inter-personal situations or specific contexts. Nowadays [26-28] most of the psychological phenomena seen in clients – their feelings, free associations, and so on – are considered specific to the particular inter-personal context, in that particular treatment, with that particular therapist. Thus, according to the inter-subjective [29,30] or relational [31-33] perspectives, ‘transference’ is seen as unique to the specific therapist and therapy. In this way, it is considered less important and/or less relevant to determine whether a particular client uses for example splitting or denial as defense mechanisms, than to understand the inter-personal situation and specific inter-subjective context in which he/she “falls apart”. The focus on this is nowadays seen as far more relevant for the psychotherapeutic work.

Developments in psychiatric rehabilitation

It seems that within psychiatric rehabilitation, there has also been a similar shift from the attempt to identify objective characteristics towards trying to understand inter-personal relationships. Indeed, there has been a growing emphasis on the portrayal of “situations” as opposed to “characteristics”. That is, instead of narrowly describing traits and disposition indicating a diagnosis such as schizophrenia, there is a growing emphasis to describe the personal and social context in which it occurs. The context, or surroundings, like a hospital surrounding, often causes the person to exhibit more severe responses, to “act” the role of the “patient”, or to “close up”. The inter-personal context, as reflected in the attributes of those that surround the person: family, health-care professionals, and community members greatly influences the rehabilitation process. It has become clearer that an atmosphere projecting trust and belief in the possibility for development and recovery has a vital impact on rehabilitation, in the same way that one projecting pessimism and frustration block the chance for change (Davidson et al., 2009).

Implications of these parallels in development

The aims of this article were to evaluate the way in which two seemingly contrasting approaches do, in fact, share similar values and perceptions, as well as to analyze and consider the impact and conclusions that can be drawn from these. Reviewing central changes over the past recent decades, in these two approaches – the psychoanalytic and rehabilitation disciplines – has illustrated that, beyond a few structural and apparent differences, their beliefs, values, theoretical and terminological development is surprisingly similar. Both psychoanalytic and rehabilitation theories now emphasize interpersonal relations and subjectivity more than they had done in the past. Similarly, they both focus on the investigation of the complex, dynamic, long term interaction between persons and their environments, more than they do on the static characteristics of the persons’ personality and complaints. Yet, it is still necessary to determine how these parallels in development influence the understanding of interventions advanced by the two approaches.

The emphasis on subjectivity firstly influences every aspect of the therapeutic and rehabilitation relationships. It increases the mutuality between the practitioner and the client, and lessens the power difference between the two, lowering the potential for abuse, which can sometimes occur when there is a gap in power between interacting people [34-36]. The increased mutuality in the therapeutic relationship not only decreases the level of potential harm, it also contributes to a feeling of solidarity and shared destiny, and thus increases empathy

and the identification between, and the internalization of, each of the participants in the interaction.

Secondly, the emphasis on subjectivity also implies that the source of knowledge about the person's problems and the marking of therapeutic goals are no longer determined through the practitioner's "objective observation" of the client's personality structure and developmental issues that have led to his/her current struggle. Therapeutic decisions are now made jointly, by both the practitioner and the client, using an ongoing negotiation process [37,38] whereby each raises their own thoughts and opinions in such a way that they are willing to influence and be influenced by the other. Such a negotiation process strengthens the relationship and enables the establishment of joint therapeutic goals.

Thirdly, the importance given to subjectivity has also led to an increased recognition of the practitioners' own personal tendencies that influence the expression of their subjectivity. Thus, the exploration of these tendencies is no less relevant than exploring those of the client. Fourthly, greater significance is given to the encounter between the subjectivities of the client and the practitioner, as a way to understand how each of them constructs their reactions to and behavior in the world. In order to investigate the subjective organization of each of the participants in a practitioner/client dyad, their personal narratives dealing with the inter-personal relationship in the encounter is explored.

The changes reviewed in the present article have taken place at a time when the social atmosphere and the status of science and knowledge have also changed, as has the perception of professionals as sources of authority. All these are contributing factors that have led to the growing convergence between the two therapeutic disciplines. In the past, the central role of the psychoanalytic therapist was to identify intra-psychic constructs that were characteristic of the client, by analyzing the client's 'transference' and their own 'counter-transference'. Therapists needed to find suitable and sensitive ways to convey these insights to the client (in the form of interpretation), and it was this that was considered therapeutic. Rehabilitation practitioners, on the other hand, needed to identify and determine the impairment in clients' social and instrumental skills and abilities, and to find a way in which to encourage them to reconstruct and develop these abilities with the help of the rehabilitation team.

The similarities in the theoretical and practical development of psychoanalysis and psychiatric rehabilitation have brought with them the formation of joint principles, which, we believe, belong to two 'lines of therapeutic action':

Engagement: Both psychoanalytic and rehabilitation practitioners need to find a way to genuinely engage with the significant experiences and subjective world of their clients [39,40]. Empathic engagement is only made possible with the combination of the practitioner's emotional and cognitive processes. These, in turn, depend on the practitioners' willingness to let themselves "drift", both emotionally and conceptually, into the client's subjective world and the individual dynamic processes that construct it [41]. Only through genuine engagement within the therapeutic encounter is it possible to understand the clients' subjective experiences, and to get to know their authentic and true selves. Engagement with this 'true self' means engagement with the part of the self that is alive within the client, and with their wishes, dreams and desires.

Further to this, only by engaging with the subjective experience of

their clients can practitioners understand the essence of their clients' issues with themselves and with the world around them, and the attempts they make to deal with these difficulties. It is in this way that the clients' influence on their surroundings and the influence of the surroundings on them can also be understood. Thus, identifying and treating the problems that clients have does not replace the need for the understanding of their distress through their own personal experience; in the same way that identifying clients' intra-psychic issues does not form the base for their development in therapy. Practitioners in mental health, by definition, are unable to give up on engaging with the personal world of their client, and out of deep empathy for their own and other's perception of the world.

In this way, it seems that the use of formal definitions, which are "objective" and external to the persons' problems and are portrayed from a distant and external therapeutic position, has become less appreciated both in psychoanalytic and rehabilitation disciplines. In order to engage with the subjectivity of the client, the practitioners must allow themselves to be enacted by their clients, as well as to cause their clients to be enacted by them, in a way that will at times break away from the strictly professional therapeutic relationship. Such enactment is a result of being drawn into the relationship and the unique engagement between its participants. It allows for different interpersonal messages, conscious and unconscious, to be conveyed; messages that are often not able to be put into words and expressed in normal conversation. In other words, the therapist must metaphorically "touch" the client and be "touched" by him/her, beyond any formal, planned, and organized therapeutic considerations. Such engagement occurs only when a true mutual influence between both participants is made possible in the professional meeting, which is also largely a personal one.

Such a process, of engagement between client and practitioner, requires that both participants will be willing to allow for significant personal involvement, and sensitivity to the other's reactions, messages, and behavior. Engagement lowers, to a certain extent, the defenses held by practitioners maintaining a traditional, distant, professional position, and raises their potential vulnerability. At the same time, engagement raises the possibility of eliciting positive and authentic change in the world of the client and in their personal struggle.

Reflection

Both psychoanalytic and rehabilitation practitioners need to be able to look at and reflect upon the powerful inter-personal processes that take place between themselves and their clients from an apparently external perspective, despite having been involved in them [42-44]. It is crucial for the practitioner to assess and reflect upon these processes both during and immediately after their actual occurrence [45]. Such reflection requires a form of split consciousness, in which the reflector needs to be able to remain aware of their own subjective experience while going through the inter-personal encounter, and at the same time to be able to see the event from an external perspective, in order to reflect upon both sides and analyze them.

The importance of reflection lies in its ability to help practitioners understand the emotional and inter-personal complications in which they are present, and to recognize their own contribution to the "social dramas" that occur between themselves and their clients. Recognizing their own contribution to these "dramas" helps therapists separate it from that of their client, and it teaches them about the subjectivity of the client and the way in which he/she functions in the world. The ability to take an "outside" view in order to look at and reflect upon

these dramas will be communicated to the client through, what is referred to in today's literature as, 'meta-communication' [46].

Through close examination of the reflective work of practitioners, clients can internalize the important mental functioning of reflection, and are thus able to acquire an important skill in inter-personal relationships. Indeed, as clients internalize the use of reflection in their own inter-personal mental functioning, they will be able to deal better with complex social situations and to advance their deep needs.

These two 'lines of therapeutic action' – engagement and reflection – are, to a certain extent, opposites of one another, yet they should come together and be viewed as complimentary of each other. Indeed, the present therapeutic perspectives within psychoanalysis and psychiatric rehabilitation require the therapist to both be involved and engaged in the client and the evolution of their relationship, and, at the same time, to evaluate them from a reflective position. Thus, one line of action – engagement – involves practitioners' emotional and affective functions, in particular, while the other – reflection – involves their cognitive and moral functions.

It must remain apparent that by emphasizing these lines of action there is no suggestion, even in the slightest, that there is reason to neglect professional and academic knowledge from the therapeutic field, or any other therapeutic responsibility. It is important to emphasize that the lines of therapeutic action mentioned in this article, still require the practitioner to find the individuality and uniqueness within every client and every therapeutic encounter and to respond to them in the appropriate way.

This responsibility also includes the acquisition of clinical and empirical knowledge about healthy and pathological human development, manifestations typical to the clinical field, and effective methods for intervention. Similarly, it is clear that the position that practitioners take in their therapeutic role must be in line with the relevant professional rules of ethics.

Conclusion

Due to the similarities in the theoretical and conceptual development of the two therapeutic disciplines: Psychoanalysis and psychiatric rehabilitation, we have argued that insights in each are likely to be relevant and of value for the other. What may seem as a vast difference, which merely expands with increased empirical knowledge and independent theoretical development, must not obstruct those looking for mutual inspiration. These are two considerable sources of knowledge, and each can provide new ways of understanding the distress of those needing their services and can suggest different methods through which to be of help.

These two disciplines include many therapists from all fields of mental health, and within each there is a lot of professional knowledge accumulated. Similarly, in each of these approaches there are also areas in which the theoretical explanations remain ambiguous and restricted. These areas, which usually have their roots in the limitations and lack of knowledge in the theories guiding each discipline when trying to explain different manifestations, also demarcate the limitations in practitioners' understanding and ability to help their clients. The existence of these problematic areas requires therapists to look for new theoretical and practical insights, as well as for inspiration, from other relevant fields. In this way, the rehabilitation and psychoanalytic approaches can each offer the other relevant explanations that may help better deal with typical issues and dilemmas. Such reciprocated

contribution across these two disciplines, which are proving to be more similar to each other than first meets the eye, also reflects wider social and cultural changes, and allows for their mutual enrichment.

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