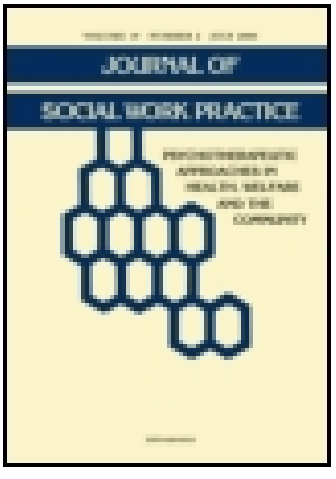

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MULTI-FACETED PSYCHIATRIC REHABILITATION TEAMS AND THEIR RELATION TO SOCIAL WORKERS' COMPETENCIES AND SELF-EXPERIENCE

Psychiatric rehabilitation social workers' professional activity takes place within a multi-faceted rehabilitation team that includes other professionals, community agents and clients' family members and its structure changes according to the clients' clinical status and recovery needs. Participating effectively in such a complex team work requires social workers' competencies of adapting, communicating, negotiating and collaborating with other professionals and non-professionals. This paper discusses the influence of the constantly changing rehabilitation environment on the social workers' professional self-experience and suggests a few implications of this phenomenon and conclusions which may contribute to professional development of social workers.

Keywords psychiatric rehabilitation; social workers' competencies; professional self-experience; rehabilitation teams

In the last two decades we witness a demand for accountability in mental health services as part of the urge for transparency and proven effectivity directed at various professionals such as police officers and doctors who provide services (Bernard and Goodyear, 2009, Watkins 2013, Rizq 2014). This demand has influenced extensively mental health professions among other health professions, by emphasizing the training and acquisition of practice competencies that have been proved as effective in achieving clients' therapeutic goals (Kaslow 2004, Fouad et al. 2009, Lemma et al. 2010).

These clinical and therapeutic competencies enable mental health social workers create an appropriate setting in which they may sense well the clinical data, conceptualize what they sense, offer their clients the suitable therapeutic instruments and assess fully their usefulness (Tuckett 2005). In social work this development has been manifested in the declaration of a competency-based outcome approach (Council on Social Work Education 2012). Competencies in social work are behaviors that demonstrate the utilization of knowledge and reflect underlying values, while the relationship with the client provides the framework for the how and why a certain type of knowledge needs to be implemented for a specific client in a specific situation (Bogo et al. 2011, Drisko 2014).

In the present article I wish to point out a certain type of competencies required from psychiatric rehabilitation social workers, because of their clinical work's unique character. These competencies include primarily the creation of mutual and egalitarian professional relationships, and the collaboration with other disciplines' practitioners, family members and community agents who take the role of care takers and participate in a working team for the benefit of the clients' welfare. In addition these competencies include the flexibility and the readiness to adapt to changing contexts of the rehabilitation environments.

I wish also to suggest a few explanations to rehabilitation social workers' professional self-experience vicissitudes and to their impact on the social workers' effective practice. These vicissitudes emanate from alterations in the social environment, developmental stages and other contextual factors, which determine people's feelings and beliefs about themselves.

These explanations are based on my extensive experience as a supervisor of psychiatric rehabilitation social workers who participate in such team-works and on contributions of the literature on the concept of the relational self. This experience consisted of giving lessons in supervision that accompanied social workers' master's degree course practicum in psychiatric rehabilitation services, a role that I filled as a member of staff. In addition, I have supervised experienced social workers working in this field, while accompanying their professional development as supervisors and rehabilitation service managers.

In the following section, I will discuss what causes vicissitudes in the professional self-experience of rehabilitation social workers who participate in rehabilitation teams and accompany clients in their recovery process. First, I will clarify the meaning of self-experience and its relevance to rehabilitation social workers' professional coping.

Psychiatric rehabilitation team work and its influence on social workers' professional self-experience

Self-experience

Self-experience is a person's individuality, which is always grounded in the body, in one's environment, in language, and is dependent on and empowered by one's history, culture, and community (Rangell 1985, Cushman 1994, Messer and Warren 1995, Aron 1996, Frie 2003). This experience shapes individuals' separation of the internal from the external, their boundaries, the reality in which they live, their continuous extratemporal and extraspatial identity, the way they will live their lives, and the meaning that they will attribute to life events (Hagman 2003). This experience constructs and clarifies the individual's uniqueness, subjectivity, and authenticity (Akhtar 2003).

The self-experience can include the experience of the individual as separate from others, or can include a connection and an interdependent relationship with others. These two separate experiences are not necessarily contradictory, but, in fact, can be mutually strengthening rather than mutually weakening (Markus and Kitayama 1991). The yearning for understanding, deep recognition, and validation by significant others strengthens and constructs the self-experience no less than the ability to be alone and to act independently (Doctors 1999). Therefore, the nature and quality of the relationships that individuals create with others in the environment, at different developmental

stages throughout life, influence the way in which they self-attribute character traits or different truths and influence their self-definition. These are determined during their development, with the help of an intersubjective system, which creates reactivity that is either more or less appropriate to their basic needs (Stolorow and Atwood 1992, Stolorow 1998, Bradfield 2011).

In addition, the development of the self-experience is dependent on the existence of the person's deep internal motivation, which is based on: "[A]n inherent tendency in human beings to grow or develop, meaning to expand in function, to self-organize with increasing complexity in keeping with basic and evolving motivational values or preferences" (Fosshage 2011, p. 96).

In the following section, I will discuss what causes three factors which contribute to vicissitudes in the professional self-experience of rehabilitation social workers who accompany clients in their recovery process.

Vicissitudes in clients' self-experience

There is little doubt that the self-experience of clients with serious mental illness undergoes many shake-ups, both because the illness leads to stark changes to their entire mental and relational system and because of variations in the reactions to them by significant others in their environment. Sometimes, they demonstrate good social functioning and sense of personal well-being, and sometimes they reach the lowest points, when narcissistic vulnerability is aroused, undermining their self-experience (Kean 2009). Many clients feel that their illness narrative sometimes dominates their central narrative and they have difficulty defining their identity without the ongoing mental difficulties.

A series of events might rock clients' self-experience, such as traumas, neuro-cognitive damage, and problems related to social attachments. These events will cause change in the clients' feeling of vitality, the richness of their personal sensations, and their sense of realness in the world. They might also undermine the clients' experience of "agency" or cause them not to experience themselves as genuinely participating in the world in which they live (Aukin 2000, Grant 2002, Atterton 2007, Lysaker and Lysaker 2010).

It is reasonable to assume that such resulting self-experiences of SMI clients will influence similar perceptions in the professional self-experience of rehabilitation social workers, with whom they interact intensely and create meaningful relationships. This might happen, for example, following developments in the clients' clinical condition, such as psychotic episodes, with the blurring of boundaries between subject and object that causes functional and emotional regression. In cases such as these, the rehabilitation social workers might feel confusion, embarrassment, and personal and professional failure, which will harm their self-image and their sense of professional self-worth. They are also able to identify with their clients' regressive experiences and might temporarily lose the perception of the clear boundary between themselves and the other and thus undermine their own self-experience. However, when the opposite occurs and their clients undergo a positive functional and emotional change, the rehabilitation social workers' self-experience may undergo parallel positive changes, which will be expressed in a high sense of self-efficacy and self-worth.

For instance, when a social worker accompanying a client with SMI in the supported employment field persuaded the client in rehabilitative therapy to try and cope with

work in the private sector with her ongoing accompaniment and support. The social worker held supervisory and informative conversations with the manager who was to be directly in charge of the client during her reception in the workplace. When the client declared that she was willing to undergo a work trial placement, the social worker felt that she had succeeded. The social worker attributed the client's agreement partly to the fact that she had not lost faith in the client's progress over time, and had therefore skillfully created an intervention in which she boosted the client's motivation to accept this challenging job. These attributions led the social worker to believe that she had greatly advanced in her professional identity formation and in her skill in patiently accompanying clients with ongoing SMI.

On the day of the intended meeting with the manager responsible for the client's new post, the client informed the social worker that she was withdrawing her agreement and that she did not feel ready for the transition toward which they had been working together. Following lengthy conversations with the client and her family, the client refused even to consider the trial period, even when offered increased professional accompaniment. The social worker sensed a huge regression in her sense of professional self-esteem as a practitioner in the psychiatric rehabilitation field, since she had invested emotionally in the client and saw this professional relationship and its development as a meaningful challenge. After the client's refusal to be accepted in the proposed workplace, the social worker felt despondent about her professional work in rehabilitation. She wondered whether she was really suited to the field in light of her human need for clear, concrete feedback and to have a clearly effective impact on her environment.

Variations in the self-definition of psychiatric rehabilitation as a discipline

The psychiatric rehabilitation, like any other professional area recognized by society, is characterized by the following three elements: (a) a distinct theoretical and systematic body of knowledge; (b) professionals authorized by clients and the wider community to carry out the work (c) a unique professional and cultural code of ethics representing specific values, norms, and characteristic symbols (Vollmer and Mills 1966, American Mental Health Counselors Association 2000). When the professionals internalize the unique knowledge, principles and values of their professional area, they attain a stable system in which they can make sense of their work and their professional life, which contributes to their sense of belonging and uniqueness (Friedman and Kaslow 1986, Heck 1990, Palmo 1999).

An established professional area that includes a culture, values, and coherent principles enables all its affiliates to create a relatively clear and consistent specific professional identity. Even though the psychiatric rehabilitation area has been undergoing unique formation for only the last three decades, the continued addition of abundant theoretical and research knowledge brings about a notable change in the practitioners' perceptions and insights, and its culture and values are reformed each time anew.

Thus the professional area discourse changes and the essence of the area is redefined, its roles and objectives change, as do its relationship with related disciplines such as psychiatry and psychology. Thus, for example, in the last two decades, the professional area's mission has become the clients' recovery and inclusion in the community instead of managing their psychiatric disabilities, while recovery is mainly subjective and self-defined by the clients (Anthony et al. 2002, Davidson et al. 2009, Slade 2009, Wang and Kapellusch 2014).

This variability in the mission of the psychiatric rehabilitation professional area and hence of its goals and values creates the need for the social workers in this area to redefine their professional roles and their relationships with contiguous disciplines. Following all this, the people in the community at large and their clients change their expectations from mental health services. This demands extensive changes in the psychiatric rehabilitation social workers' self-image, sense of professional meaning, and other aspects of their professional self-experience.

Participation in a multi-faceted team: The "professional relational self"

Rehabilitation social workers do not work alone when accompanying recovery clients: In most cases, they are part of a team of non-professional care-takers and other professionals who cooperate to advance the clients' personal recovery goals. Simultaneously, they must develop and maintain ongoing rapport with the clients, as well as good working relationships with family members and other team members such as doctors, teachers, other helping professionals and community agents (Finch 2000, Mueser et al. 2003, Freeth et al. 2005, Gill and Turjanick 2005).

This professional work schema has been set because the functions relevant to psychiatric rehabilitation are so varied that one professional cannot be expected to master them all. Hence, the optimal solution is to appoint a multi-faceted team to advance the clients' recovery. Similar to working with addiction, psychiatric rehabilitation demands a variety of points of view and modes of intervention by community agents, primary care-takers and professionals such as nurses, psychologists and occupational therapists (Stroud et al. 1985, President's New Freedom Commission on Mental Health 2003, McAllister et al. 2014).

Therefore, rehabilitation teams are formed, which specialize in interventions for SMI clients in employment, leisure, housing, and other life areas. These teams might include experts in both traditional mental health talking treatments as well as in non-verbal expressive disciplines (such as art, music, and movement) to extend the clients' options for help. The larger rehabilitation team can provide a variety of lenses through which to observe and understand clients' experiences and challenges, when each one can identify sensitivities and particularly their strengths. The people on the rehabilitation team together, through their supportive work with a specific client, create a kind of family who can "nourish" the client and respond to his or her needs using shared and combined strengths (Cohen 2011).

Within the rehabilitation team are not only professionals from contiguous or complementary disciplines and people with roles in the community, but also the client's family members who function often as the main or the prime care takers. They are the ones who are better than others at early identification of changes in the client's clinical and emotional condition, and the ones whom the client will trust more than others. The research literature, which refers to them as primary caretakers, expresses increasing acknowledgment of the fact that they are not only capable of providing the client with better care, but, in many cases, might also advance their recovery better than any professional (Osher et al. 2001, Burgess et al. 2011).

Family members engage in care and rehabilitation, since the illness of any family member has a huge impact on all aspects of family life: the home environment, their work, the way they spend their leisure time, housekeeping and relationships with people outside the family. Just like physical illness, mental illness causes everyone tremendous

suffering and identification with the client, and therefore family members pull together to support the ill family member in treatment and rehabilitation (Szmukler et al. 1996, Rose 1997, Tessler and Gamache 2000). Parents, siblings, and other family members accompany the clients in their contact with different professional authorities and struggle to realize their social rights. Therefore, family members can be considered as an integral part of the rehabilitation teams alongside the professionals and community agents, such as religious and educational figures.

The existence of an entire rehabilitation team imposes interactions and coping situations on rehabilitation social workers, which do not appear in psychotherapy with people without SMI. They must invest in and preserve relationships with all the other team members, even though the relationship with the client is the most important of all. In this manner, a complex system of mutual influences is created within the team as well as of ongoing negotiation among them regarding boundaries, expectations and roles.

These will shape the rehabilitation social workers' interventions as well as different aspects of their self-experience, and specifically their professional self-experience and self-image; perception of their professional self-efficacy; perception of the reality in the rehabilitative space, etc. Hence, the rehabilitative space becomes an interpersonal and professional context, whose nature is determined according to the client's stage in his or her recovery process, those involved and their different roles, as well as the rehabilitation program that is created with each of the clients.

For example, in addition to the treatment by the doctor since the beginning of the rehabilitation process, a client might also need the support of a personal rehabilitation social worker, who acts as case manager, and of one family member. Later, staff from the hostel to which the client is due to move might join the team, such as a psychotherapist and art therapists. Each of these contexts involves specific communication, goals, and action strategies, and evokes unique reactions and self-experiences in the rehabilitation social worker.

This part of the rehabilitation social worker's professional self, which appears in the context of the rehabilitation team while supporting the client, can be called the "professional relational self", which is derived from a concept of the "relational self". The literature defines the relational self as a component of the self that develops as a result of an individual's contact and ongoing negotiation with the interpersonal environment, and which includes verbal and nonverbal communication and responses to the communications of others (Modell 1993, Wink 1994, Meissner 2000, Yerushalmi 2013). Every interpersonal context produces unique aspects of the self, which are gathered together in an overall, more or less coherent, relational self (Gergen 1991).

The relational self will always express an innate human goal and struggle for contact and closeness with others, that is to say for attachment, belonging, affection, connection, responsiveness, and intimacy. The relational self can be fulfilled via interpersonal phenomena such as empathy, sympathy, attunement, and resonance, which make people feel known and seen by others (Fiscalini 1991). Parallel to the relational self, the professional relational self can be the same part of the self that is expressed in professional interpersonal circumstances and environments and which allows professionals to realize their relational needs. Here, it is noteworthy that psychiatric rehabilitation social workers' professional relational self is different from that of psychotherapists or other helping professionals.

Rehabilitation social workers' professional relational self is influenced largely by the need to adapt to distinct rehabilitative contexts in which they act. In some of these contexts, the rehabilitation social workers will feel connected and close to the client or to others on the team who believe in their abilities and intentions, whereas in other, more challenging situations, they will feel excluded and alienated to some extent.

The latter situation might occur, for example, when the context is rehabilitation work with a client who is sometimes verbally violent or in a context in which a competitive, hostile environment exists among the professionals co-working in the rehabilitation. In addition, rehabilitation social workers might feel stronger in some contexts in their definition and understanding of their interpersonal reality, while in others these may be undermined when encountered with conflicting perceptions of reality.

The professional make-up of such work groups might also change from being a team that includes a doctor, a community nurse, and a social worker to a rehabilitation team that includes an occupational therapist and a community worker. In both cases family members, teachers, clergy persons and other community agents may also participate. These differences in the nature of the rehabilitation teamwork undoubtedly encompass different reactions and the rehabilitation worker moves between completely different professional relational self-experiences.

The implications of vicissitudes in rehabilitation social workers' professional self-experience

1. The vicissitudes in psychiatric rehabilitation social workers' professional self-experience may be important in light of the emotional distance and alienation that is sometimes created between the rehabilitation social workers and their clients because of the client's mental illness' symptoms and a stigma toward the illness. The similarity between social workers' experience and that of clients with SMI In this way, may help the social workers to resonate and identify with their clients. Thus, for example, they may empathize better with their clients' wish for functional regression or their fatigue with constant coping with challenges. Through such identification, the rehabilitation social workers can have a better understanding of their clients' fragility and instability in their sense of self-worth and in their perception of reality. This type of attuned and empathic understanding contributes to more effective interventions and strengthens the relationship between the clients and the rehabilitation social workers.
2. The acknowledgement that rehabilitation social workers' professional self-experience is unstable and constantly changing demands that supervisors and colleagues accompanying them in their professional career will give the matter some thought and assist them to focus their attention on these issues. This ongoing task becomes increasingly complex and rich, the more professional experience they accumulate with different teams. An illustrative example is of a social worker who began working in the psychiatric rehabilitation field in sheltered housing about a year before. The social worker had been a consumer of mental health service himself, who specialized in psychiatric rehabilitation. He was delighted to have been accepted to the job and was very excited about starting work as a rehabilitation practitioner. He was appointed to accompany several clients and as the facilitator of a group of other clients. After several weeks, the social worker turned to his supervisor and explained that he had recently been

feeling depressed. He was convinced that several of his clients had "infected" him with their depression and he expressed concern that he might not be suited to this type of social work. He added that this work might be bad for him because he felt flooded by others' distress.

The supervisor drew his attention to the fact that, when he had first started the job, several members of the rehabilitation staff had expressed their difficulty with the fact that he was a client himself and were concerned that he might not be up to the job. She helped the supervisee to construct his personal-professional narrative, in which he had come a long way in self-development as a social worker with practical knowledge and experience and in how he had had to cope with unexpected difficulties with colleagues who had doubted his ability as a practitioner to cope with mental health issues. His personal story of depression was linked to his helplessness and anger toward his rehabilitation colleagues and was not the result of his professional encounter with clients or of his personal-professional traits. Following this discussion, the social worker-supervisee felt renewed hope about his development as a practitioner and, through role play together with the supervisor, planned a better way to present his professional self when collaborating with work colleagues in the future.

Since the self is always defined in relation to the other and vice versa, changes in self-perception and the way in which people define themselves will lead to changes in the way they perceive and define the other. Therefore, as the development of the rehabilitation social workers' professional self-experience advances and becomes more rich and complex, so does their perception of the client, the client's family, and other professionals.

3. Besides the comparisons and parallels drawn with the clients, the professionals, and other community workers in the team, the rehabilitation social workers' professional self-experience is accentuated to a great extent through comparison with the activities of the client's family members in the rehabilitation team. Family members often influence the definition of the rehabilitation practitioner's professional identity and his or her professional relationship with the client, precisely because the family members' activity is not professional in any way. Although rehabilitation social workers' mental states and emotions are similar, in certain ways, to those of a family member, they are different because of their professional stances and perceptions.

Thus, for example, rehabilitation social workers can feel closeness and intimacy, fondness and identification toward the client, but these are partial and transitory states. They must remember the fact that they are professionals who must evaluate the client's clinical condition and needs as objectively as possible. In addition, they must take particular care to remember that the relationship with the client is limited to the professional interaction and is subject to its rules, and that the end of the professional interaction is also the end of the relationship with the client. Therefore, it is the participation of family members in the rehabilitation process as part of the client's supporting team that, by its contrast to the professional contribution, may contribute to the formation of the rehabilitation practitioner's professional self-experience.

Conclusions

One conclusion concerns the competencies of collaborating and communicating with other professionals and non-professionals in the teamwork, which implies flexibility and on-going negotiation with other sets of values and perspectives, seem to be essential for psychiatric rehabilitation social workers. In contrast with psychotherapy rehabilita-

tion social workers need to find a common language with other team members, move sometimes to the front of the professional activity arena and then move to its back, assimilate and influence others with different value systems and perspectives. They should be capable to relate to other points of view and the richness of voices with regard to the rehabilitation environment and the client's needs and mental states. These competencies should be the goals of training in this professional area along with more traditional ones as empathy and sensitivity to others' emotional states.

Another conclusion concerns the long term effects of the vicissitudes in rehabilitation social workers' professional self-experience. These vicissitudes may advance their professional and personal development because they strengthen the sense of continuity in their personal and professional existence. Paradoxically, self-experience that is repeatedly deconstructed and reconstructed is strengthened: each reconstruction forces the person to look back and thoroughly revisit his or her past perceptions and sensations. Such retrospective and reflective observation alongside authentic attunement to the current situation will advance the formation and establishment of the person's self-experience and the sense of continuity of his or her existence (Herzog 1984, Akhtar, 2000, Arango 2003).

To perform such reflective and retrospective observation of perceptions, definitions, and sensations toward components of the self, people require two opposing conditions. On the one hand, they must sense the need for self-observation and be sufficiently calm to explore and connect to unknown parts of the self-experience to be able to spell them out. Confidence in the environment will enable them to examine their reactions and stances calmly, while constant threat and incessant anxiety may disrupt the reflective, organizing process that is required to form a stable and coherent self-experience. On the other hand, people must experience a certain degree of undermining and anxiety when occasionally faced with new challenges, to move closer to unknown aspects of the self and to establish and deepen their identity. Renewed undermining of the self-experience because of new and unfamiliar intersubjective contexts will enable its reexamination and enrich its organization.

My experience in supervising social workers, who are constructing and developing their professional identity in a non-linear manner, shows that examining the social workers' professional self-experience in the psychiatric rehabilitation field and supporting its formulation and organization is, in many cases, no less important than understanding SMI clients' clinical condition and the challenges they have to face. This experience shows that observation of this process of construction, deconstruction, and reconstruction of their professional self-experience and understanding the meanings of these processes leads to greater professional ability among social workers dealing with psychiatric rehabilitation.

Finally, I wish to emphasize the need for a further empirical study on the described phenomena and the conclusions suggested in this article, which were based on a long clinical and supervisory experience.

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