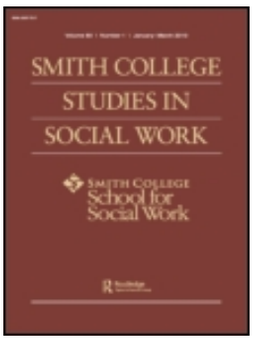

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Psychodynamic Supportive Psychotherapy Techniques in Clinical Social Work Practice with Parents

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In this study, the author researched his clinical practice in a community mental health center with six parental couples whose latency-aged children suffered from prevalent separation anxiety disorder symptoms. Through thematic analysis of the anamnestic process recordings of 53 parent sessions, the author's speculation on the effectiveness of the supportive psychodynamic psychotherapy techniques to psychodynamic clinical social work practice with parents was confirmed. Nine of thirteen supportive psychodynamically grounded therapy techniques were highlighted, whereas the clinical practice produced three more. The techniques permeated and shaped the author's clinical social work intervention, and a follow-up confirmed the reduction in mental health symptoms for the children and also increased parental satisfaction in response to the interventions.

KEYWORDS psychodynamic, supportive psychotherapy, techniques, clinical social work, parents, practitioner research

BACKGROUND

The limited knowledge of the application of theories in social work practice has resulted in the absence of a cohesive practice model (Osmond, 2005) capable of reflecting the knowledge base of the profession (Gould,

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2006). Drisko (2000) documented a research gap in the mental health field, after analyzing detailed descriptions of various therapies for mental health problems of children and adults. In the child mental health field, the work with the parents is regarded as the most difficult part as well as the reason why child psychotherapists seek training in adult psychotherapy (Rustin, 1998). In fact, there is a degree of practice identity uncertainty about this type of work because parents approach the child psychiatric services seeking treatment for the child and not for themselves (Siskind, 1996).

An answer to the aforementioned problems is "practitioner research" that aims to understand practice through reflexivity and to improve effectiveness (Gibbs, 2001). Reflexivity is the ability to recognize the influence of the researcher's whole self and context on every aspect of the research, and the ability to use this awareness in the research act itself (Fook, 2001). In this study, I adopt "process reflection" that draws on psychodynamic theory and studies the unconscious as well as the conscious aspects of practice through emphasizing the practitioner's unavoidable impact on the emotional content of interactions (Ruch, 2007). Practitioner reflective research has the potential to offer an effective answer (Karpetis, 2010a) to recent studies indicating that social work practitioners apply social work research findings to a rather limited extent, possibly owing to their reduced quality, accessibility, and applicability to the field (Trevithick, 2007).

In this study, I employ the collective case-study research method to study retrospectively my own psychodynamic clinical social work practice with six parental couples who referred their child to a Child and Adolescent Community Mental Health Center for heightened prevalence symptoms of separation anxiety disorder (SAD).

LITERATURE REVIEW

Theory and Conceptualization

According to Anna Freud (1966), the cause of SAD is the unconscious aggression that the mother/parents direct toward the child, to whom intensely ambivalent emotions are consequently generated. The child's (unconscious) oscillation between love and hate for his parents can only be relieved through their constant physical presence; otherwise he or she experiences intense anxiety (due to anger) at their actual or impending departure (e.g., school phobia symptoms). Klein (1936) extended Anna Freud's view, maintaining that losses are an inevitable part of the oedipal phase and that they are foreshadowed by earlier losses. The first loss that the infant has to overcome is the loss of the breast during weaning. Later on, oedipal loss is followed by recognition of the parental sexual relationship, the relinquishment of the idea of the permanent possession of the mother and other external objects and their establishment within the psyche.

Attachment researchers pointed out the relation between secure attachments in parents with security of attachment in their children, even to the extent that attachment security in children can be predicted by assessing parental attachment before the child is born (Fonagy, Steele, & Steele, 1991). The security of attachment in children is affected by the view that each parent has of his or her own attachment history (Target & Fonagy, 2002). Bowlby (1960) and Ainsworth, Blehar, Waters, and Wall (1978) set the stage for understanding the origins of insecure and secure attachment that affect a child's capacity to separate. When parents are responsive to the needs of the child, the emotional bond created provides a lasting sense of security even when the parent is not present. Insecurely attached children experience difficulty whenever they separate from their parents. The reaction of children with SAD to separation from parents is very similar to that reported of the disorganized and ambivalent insecurely attached children in Ainsworth's strange situation test (Weems & Carrion, 2003), according to which children protest vigorously on separation and are hard to console on the parent's return. Accordingly, children with SAD protest desperately when separation is imminent, cry and become agitated during separation, and then may act angrily or aggressively toward the parent on return (Ollendick, Lease, & Cooper, 1993).

Understanding parenting from a psychodynamic perspective involves an understanding of the ways in which parents apply their relational and educational skills to their children. The family is a defensive organization, in which each parent has unconsciously chosen the other in order to fit with—and enact—his or her own projections (Bower, 2005). The frequency and extent with which the parental images are projected onto the child determine the extent to which children behave like their own parents (Davids, 2002).

Intervention

Based on the ideas of Sutton and Hughes (2005), Horne (2000), and Rustin (1998), the aim of intervention with parents is the assessment and treatment of parental aggressive behaviors and attitudes (passive or active, direct or indirect, conscious or unconscious) toward the child. The intervention objectives include (1) the revelation of the causes of the child's symptoms, (2) the understanding of those parental behaviors and attitudes that enhance child psychopathology, (3) the safeguarding of uninterrupted parental participation in the child therapy process, (4) the enhancement of the motivation of parents and children for engagement in the therapeutic process, and (5) the enhancement/ strengthening of the supportive parental roles (Karpetis, 2008).

The need to work with the client's family (here with the parents) is stressed in the supportive psychotherapy literature. Rockland (1989) indicated the necessity for direct intervention in the client's environment

and the patient's relatives; Winston, Rosenthal, and Pinsker (2004) stated that supportive psychotherapy may entail much of what is described as relationships with family, friends, coworkers, and neighbors; and Kay and Tasman (2006) characterized the work with the patient's significant others as an effective supportive psychotherapy technique.

Although recently systematized (Kay & Tasman, 2006), supportive psychotherapy was developed out of the practice of psychodynamic psychotherapy (Kernberg, 1984) and adopted a psychodynamic understanding of the patient's difficulties through the employment of a body of techniques (Winston et al., 2004), such as clarification and confrontation, derived from psychoanalysis (Kernberg, 2004). Historically, Schilder (1938) noted that supportive psychotherapy consisted of discussion, advice, persuasion, appeal to willpower, hypnosis, suggestion, relaxation, concentration, and hospitalization. Levine (1945) added to Schilder's list the techniques of reassurance, authoritative firmness, and education. Subsequently, Bibring (1954) stated that supportive psychotherapy includes suggestion, abreaction, manipulation, clarification, and interpretations. The first two books exclusively devoted to psychodynamic supportive psychotherapy were written by Werman (1984) and Rockland (1989).

In contrast to expressive psychotherapy, supportive psychotherapy authors deemphasize transference interpretation, avoid the analysis of the patient's defenses, and aim to strengthen clients' egos in order to help them cope with interpersonal and environmental difficulties in the present situation (Person, Cooper, & Gabbard, 2005). Supportive psychotherapy has been successfully employed to treat various psychiatric disorders like depression, anxiety disorders, schizophrenia, substance use disorders, and personality disorders (Buckley, 2009). It has also been successfully applied in a wide spectrum of problems of higher functioning patients (Winston et al., 2004).

Techniques

According to Pippard and Bjorklund (2003), techniques are specific, repeatable, demonstrable, and measurable actions to be applied in appropriate contexts. Practitioners either know a technique and the way it is applied, or they don't. Techniques assist in the implementation of intervention models, and without them implementation of any theory or model is awkward, at best, and wholly impossible, at worst. Although research into techniques is rather infrequent in social work literature, a recent study (Spirito et al., 2011) indicated that when social workers work with suicidal adolescents they employ more humanistic techniques than their counterparts in psychiatry and psychology who seem to prefer cognitive-behavioral, psychodynamic, and family system techniques.

Various techniques, principles, methods, strategies, and competencies exist in the psychodynamic supportive psychotherapy literature. Although most authors seem to agree on the identification of certain supportive

TABLE 1 Theoretical Conceptualization of the Supportive Psychotherapy Techniques According to Various Authors

Present Study Techniques	Werman (1984)	Rockland (1989)	Novalis et al. (1993)	Pinsker (1997)	Kernberg (2004)	Kay & Tasman (2006)	Gabbard (2009)
Exploration				✓			
Clarification	✓	✓	✓	✓	✓	✓	✓
Reframing		✓		✓			✓
Establishing boundaries	✓			✓			✓
Environmental intervention	✓	✓			✓	✓	✓
Confrontation	✓	✓	✓	✓	✓	✓	✓
Offering advice	✓	✓		✓	✓	✓	✓
Interpreting transference	✓		✓	✓	✓	✓	✓
Emphasizing strengths	✓	✓	✓	✓	✓	✓	✓
Facilitating therap. alliance	✓	✓	✓	✓	✓		✓
Accepting abreaction	✓	✓	✓	✓	✓	✓	✓
Offering education	✓	✓	✓	✓	✓	✓	✓

psychotherapy techniques (Table 1) that contain identifiable behavioral components (e.g., reframing, advice offering), some variations appear in the content of other supportive psychotherapy techniques that seem to include abstract or multiple/complex behavioral components (e.g., conveying a sense of sympathetic understanding). A few of the most frequently cited authors who have elaborated on the content of supportive psychotherapy techniques are Werman (1984), Rockland (1989), Novalis et al. (1993), Pinsker (1997), Kernberg (2004), Kay and Tasman (2006), and Gabbard (2009).

The first group of the techniques described by Rockland, and accordingly targeted for research in the current study, are (1) "facilitation of the therapeutic alliance," which aims to convey the message that the therapeutic relationship is a joint endeavor by both the parties/participants; (2) "furnishing reassurance and hope," which reveals the client's strengths and assets; (3) "giving suggestions and advice" on client's relationship problems, which attempts to strengthen the client's ego (Ornstein, 1986); (4) "educating the patient," which involves sharing educational material with the patient regarding the problems he or she faces; (5) "accepting abreaction," which helps clients to bear painful emotions through identifying with the clinician; (6) "making environmental interventions" into the family, work, and community, to increase the client's adaptation; (7) "offering reframing" on the client's

understanding of his or her own problems via the clinician's perspective; (8) "giving encouragement and praise" whenever the client hesitates to self-assert or to become involved in ego-strengthening relationships; (9) "making prohibitions and setting limits" targeting the maintaining or restoring of the focus of the therapeutic process on the agreed aims of the intervention; (10) "emphasizing strengths and talents and encouraging sublimations" mostly for the client's aggression; (11) "using somatic/ medical treatments"; (12) "making clarifications" that reveal the client's cognitive and emotional understanding of problems; (13) "using confrontation" that discloses contradictions between the client's narratives and behaviors as well as insight into the existence of defenses or internal conflicts; (14) "furnishing a model for identification" for the client to employ the ways the clinician deals with problems.

The second group of techniques that fall within the exclusive domain of psychoanalytically trained clinicians and contain multiple and/or abstract behavioral components are (1) the strengthening of adaptive defense mechanisms, (2) the undermining of maladaptive defense mechanisms, (3) the use of benign projections and introjections, (4) the determination of the style of interventions according to the understanding of the client's transference, and (5) the combination of the techniques of both groups.

Current Study

I was prompted to study the clinical identity SAD by (1) the shortage of studies on the application of psychodynamic supportive psychotherapy techniques in clinical social work practice with parents, (2) the clearly identified symptoms of the disorder according to the *Diagnostic and Statistical Manual of Mental Disorders IV Edition* (*DSM-IV*; American Psychiatric Association, 2005) and the ICD-10 diagnostic manuals, and (3) the necessity for the work with parents during the child therapy process according to the prominent theoretical approaches—and particularly the psychodynamic approach—in the child mental health field (American Academy of Child and Adolescent Psychiatry, 2007). I employed the supportive psychotherapy approach because (1) it is regarded as one of the (if not the) most practiced forms of individual psychotherapy (Ursano, Sonnenberg, & Lazar, 2004; Winston et al., 2004), (2) it adopts a psychodynamic understanding of the patient's difficulties, and (3) employs a body of specific techniques (Winston et al., 2004).

METHOD

Based on the above literature review, I explore (1) how supportive psychodynamic psychotherapy techniques may be effectively applied to psychodynamic clinical social work practice with parents and (2) the

possible effectiveness of the application of psychodynamic psychotherapy techniques in the improvement of the parents' role and the reduction of the child's separation anxiety symptoms.

For this study I was influenced by a psychodynamic understanding of parenting and SAD and particularly the supportive psychodynamic psychotherapy techniques (Rockland, 1989). Through adopting a specific theoretical perspective, I attempt to reply to the argument that practitioner research is untheorized and consequently impeding the critical engagement with the phenomena in question (White, 2001). Another argument that refers to the impossibility of the practitioner researching himself (Padgett, 2004) is countered in the work of Devereux (cited in Giami, 2001) who questioned the so-called objectivity of the researcher and labeled as "researcher countertransference" the researcher's unavoidable bias toward the research subject, the research tools, and himself or herself.

As noted by Spence (cited in Midgley, 2006), the clinical case study is a type of psychological research method in which the research subject is the practitioner who represents the intervention act. Even though four cases are typically selected in the multiple case-study research method (Creswell, 2000), in this study I have researched six cases, expecting that they would produce rich data on the phenomenon in question.

The importance of researching techniques is apparent in the psychodynamic bibliography. For example, Gabbard and Westen (2003) noted that any theory of therapeutic action should ideally contain the aims of treatment and the strategies that facilitate change—namely the techniques applied. In the social work literature, Pippard and Bjorkland (2003) noted that neither practice theories nor models can be implemented without techniques, and Thyer (2007) pinpointed the need for social work education to focus on teaching certain therapeutic techniques.

The techniques I have employed in this study draw from Rockland's (1989) model because (1) it is extensively referred to in the supportive psychotherapy literature (e.g., by Barber, Stratt, & Halperin, 2001; Gabbard, 2009; Kernberg, 2004; Novalis et al., 1993), (2) it is regarded as suitable for researchers (Gabbard, 2009), and (3) it divides the techniques into two major categories: those that can be used by a nondynamically trained clinician and those requiring psychodynamic knowledge and skills. The first group of techniques seemed to comply with clinical social work practice because practitioners are not required to (and usually do not) have a formal training in psychoanalytic psychotherapy. Additionally, Rockland's techniques had certain similarities with psychodynamic clinical social work practice, regarding their common emphasis on (1) the importance of forming a therapeutic relationship, (2) intervention in the client's environment, (3) the adoption of the strengths perspective, (4) the importance of strengthening the client's ego, (5) the concentration on the demands of reality, and (6) the understanding of the client–clinician relationship in the 'here-and-now' situation.

Sample Participants

The six cases were the first to approach the Community Mental Health Center after the study began, seeking therapy for prevalent SAD symptoms in their child. They went through the whole assessment phase. Four of the children were age 6 years, and two were age 8 years. All the children (five girls and one boy) were primary school students, and two of them were the only child in the family. All the families were natural and nuclear; the parents were middle aged; in all cases the father was working, whereas the mother was working in three cases. The financial status of the families ranged from low to medium, and the educational background of the parents ranged from primary school graduates to postgraduates (Table 2).

Because the research setting was naturalistic, no alteration being made for me to comply with the research aims. I used no recording device as I considered it an intrusion (Brandel, 2004) into the research setting. In the beginning of the assessment phase, parents gave their verbal consent to the anonymous use of the intervention data for research purposes (a standard procedure suggested to all families visiting the Center). After the work ended, the six parental couples willingly consented to the anonymous publication of the research findings (a possible indication of the strength of the therapeutic alliances).

To reveal the potential sources of biases (countertransference), I describe the hosting organization and my professional self in relation to my training, work experience, and theoretical orientation to clinical work with the parents. At the time of the intervention, I was a postgraduate student in social work. I had acquired training in psychodynamic social work practice at the Tavistock Clinic (London) and completed an introductory training in child psychoanalytic psychotherapy (2 years of psychoanalytic baby observation and 5 years of personal psychoanalysis). I additionally had 4 years of full-time work experience with parents in a deinstitutionalization hostel for children with emotional and developmental disabilities, 5 years of full-time practice experience with parents in a Child Guidance Clinic, and 10 years of part-time work experience with parents in a therapeutic unit for psychotic and autistic children. The scientific directors of the above-mentioned organizations were psychoanalysts or training psychoanalytic child/adult psychotherapists.

The hosting organization was an urban Community Mental Health Center for Children and Adolescents. The interdisciplinary team members followed the psychodynamic approach, according to which the work with parents was mandatory and a prerequisite for achieving therapeutic results. If the parents refused to collaborate, the work with the child would not begin (Lush, 1998; Reeves, 1988). The parent work took place on a fortnightly basis and accorded equal importance to the participation of both parents (Karpetis, 2008). A parent was expected to call and provide initial information on the child's problem. In a subsequent interdisciplinary team

TABLE 2 Socioeconomic Status of the Families

Child	Age	Composition of Family	Parental Socioeconomic Status	Parent Education	Parent Sessions	Parent Mental Health Issues
Christina	6	Father: age 39 Mother: age 29 Brother: age 12 Parents married for: 13 years	Father works as a public servant. Mother works as a housewife. Both grew up in poor farming families. Current financial difficulties	Father: Primary school Mother: Primary school	18	Father: Abused the mother; Past drinking problem (emotional) Mother: Enuresis until she was 11 years old; Phobias and separation anxiety symptoms until today; Current obsessive and depressive symptoms; Suffered emotional and bodily abuse from the father
Andrew	6	Father: age 42 Mother: age 38 Sister: age 9 Parents married for: 10 years	Father is an engineer. Mother works as a nursery teacher. Middle social class	Father: PhD Mother: Tertiary education	12	Father: Obsessive personality characteristics; Tension in the couple relationship Mother: Emotionally traumatic separation at age 7 due to family's migration from abroad
Maria	6	Father: age 40 Mother: age 36 Sister: age 5 months Parents married for: 7 years	Father works as a public servant. Mother works in a company. Lower/middle class	Father: Secondary school Mother: Secondary school	4	Mother: Bodily abused by her father; Dependent and depressive personality characteristics; Spastic colitis

(*Continued*)

TABLE 2 (Continued)

Child	Age	Composition of Family	Parental Socioeconomic Status	Parent Education	Parent Sessions	Parent Mental Health Issues
Lena	8	Father: age 40 Mother: age 41 Parents married for: 13 years	Father works as a public servant. Mother works as a housewife. Working-class family	Father: Primary school Mother: Secondary school	9	Father: Anxious and phobic personality characteristics Mother: Hypochondriac fears; Dependent personality characteristics; Past serious problems in the couple relationship
Eleni	8	Father: age 40 Mother: age 35 Sister: age 4 Parents married for: 9 years	Father works as a teacher. Mother works as a part-time teacher. Father came from a middle-class family. Mother came from working-class family.	Father: Tertiary education Mother: Tertiary education	4	Mother: Depressive personality characteristics; Anxious for not having a full-time job; Her family was overprotective
Vasso	6	Father: age 41 Mother: age 34 Sister: age 15 Parents married for: 16 years	Father works as a public servant. Mother works as a housewife. Father came from a working-class family. Mother came from a middle-class family.	Father: Primary school Mother: Secondary school	10	Father: Unable to set boundaries in the relationship between his wife and his mother-in-law; Depressive personality characteristics Mother: Serious dependent personality characteristics; Probable depression

meeting, a practitioner undertook the assessment of the child, and the clinical social worker undertook in parallel the assessment of the child's parents. The biopsychosocial history of the child and his or her parents, and the following assessment of the parenting problems gave to the practitioner a first picture of the complexity of influences. This preliminary assessment then set the stage for proposing a treatment plan for the work needed for child and parents. The assessment results were discussed with the parents in a subsequent meeting, at which the parental consent/agreement for any suggested intervention was secured.

Data Collection

After appropriate consents were obtained, the six cases were selected based on the following criteria: (1) the children fulfilled the criteria for the SAD diagnosis, (2) the six parental couples and their children went through the assessment phase (in fact, those six cases have completed the minimum clinically required work needed for child and parents), thereby providing rich research data, (3) I had approached the clinical work with parents after 5 years of supervised clinical experience at the Center. In fact, my work at the center was "indirectly supervised" through my participation in clinical and case-presentation interdisciplinary meetings. Institutional Review Board permissions and consents were obtained, and all cases have been carefully deidentified to protect confidentiality.

The research data in a clinical case study include archives, interviews, questionnaires, and observations (Meyer, 2001). The unavoidable researcher bias (countertransference) in case studies is dealt with through (1) anamnestic process recording right after the end of each session (Klein, 1961), (2) clearly stating the speaker when quoting session narratives, (3) describing nonverbal client communication, and (4) reporting the thoughts and the countertransference of the practitioner (Klumbner & Galatzer, 1991).

Because the study of the clinical intervention with parents mostly reflects the study of the therapeutic relationship developed between the parents and myself in the role of the clinical social worker, the research data of this study include (1) my detailed anamnestic-process recordings of the 59 parent sessions, written right after the end of each interview (Midgley, 2006); (2) the child therapists' notes of the child therapy sessions; (3) the minutes of the multidisciplinary group meetings held to consult on these six treatment cases; and (4) the semistructured telephone interviews I conducted with the parents, a year and a half after the intervention ended.

I had worked with the six parental couples on a fortnightly basis, for a period of 3 to 14 months. Christina's parents attended 18 sessions, Andrew's parents attended 12 sessions, Maria's parents attended 4 sessions, Lina's parents attended 9 sessions, Eleni's parents attended 4 sessions, and Vasso's parents attended 10 sessions (Table 2).

Data Coding and Analysis

I coded all sessions between me and each parental couple, so that the clinical process could be depicted as fully as possible. Every participant's narrative was coded into a spiral form in a time sequence, according to which each parental narrative prompted my intervention, which in turn resulted in a parental comment, and so forth. The data coding took the form of a six-column table (Figure 1).

A within-case thematic analysis ensued in each of the six cases. "Themes" are those recurring interventions that require a distinct and necessary skill on the part of the practitioner. The themes appear through searching for patterns of meaning and issues of potential interest in the data. Because theme identification involves the researcher's judgment (Brown & Clarke, 2006), I should make clear that I identified the themes of the current through (1) applying the supportive psychodynamic psychotherapy techniques (Rockland, 1989) as a theoretical point of reference and (2) identifying theme repetition because the most obvious themes in the corpus of data were those topics that occurred and reoccurred (Ryan & Bernard, 2003). The results of the data analysis were the themes—or otherwise the techniques—I applied in each of the six cases.

Eleni Case

	Time Sequence	Parent Narrative (A)	Clinician's Intervention (B)	Outcome of the Intervention/ Parental Reply (C)	Clinician's Thoughts (D)	Themes/ Techniques
23	**Mother 2nd session**	Since the beginning of school (on Monday), Eleni has been happy and returns home carefree. She said she solved the problem with her friends. She also decided to play with her sister.	Quite an improvement! Why do you think she has changed?	I don't know. After her therapist talked about her difficulty to get angry, she told her friends "get off me." She said that, although she still has some thoughts, she believes that she will get over them.	The father was busy. There was a big change in Eleni and a reduction of symptoms. The mother connected Eleni's improvement to the child therapist's words about her anger. I believe that the previous meeting with both parents also played an important role, since the child's dependency needs were also discussed.	Exploration
24			You say that there is still some difficulty, but Eleni is optimistic that she will get over it. How do you feel?	I understood that my child grew up and that she is able to stand on her own. She is right when she says 'no' to me. Perhaps all this should happen so that I will change my attitude toward her and understand that she grew up. During Christmas vacation, she said 'leave me alone' and she also kicked her father.	The positive effect of my intervention to the mother is confirmed. The mother was able to understand and use my intervention. The mother used to treat Eleni as a baby (overprotection) and was unable to accept the child's anger. The signs of Eleni's aggression were an indication of the reduction of her 'separation anxiety.'	Clarification
25			You look surprised!	I would expect such reactions after 12 years old.	Probably the mother has difficulty with her anger and this might be the reason she inhibits it in Eleni.	Confrontation
26			There must be reasons for you to say so. In fact, we can discuss it after we understand Eleni's personal history/ development.	The mother said that Eleni was a happy baby; breastfed for seven months; had normal developmental milestones; used a transitional object. She adapted well in the nursery. When she was five, her sister was born and, for the next few months, she (asked and) slept with her mother. When she was in the first grade of primary school, a health problem - a lymphangioma - was accidentally discovered in her.	I state the importance of the mother's words, but I return to Eleni's psychosocial history where she appears to regress when her sister was born and when the mother (together with the father) allowed her to sleep in their bed. I should further explore Eleni's health problem.	Establishing the boundaries of the setting/ exploration
27			What does the lymphangioma mean for her health?	Doctors have different opinions; some say she should get a surgery, others say we should wait. Since I am afraid for the child to have a surgery, we wait, despite some others' opinions that waiting is risky.	I feel that Eleni's health problem brings about even more anxiety for the parents. They seem unable to trust a doctor; therefore, they undertake the doctor role themselves. I wonder whether this is the result of their overprotection toward the child.	Exploration

FIGURE 1 An Example of Data Coding and Analysis

After coding each case and identifying the techniques, I performed a cross-case analysis (Stake, 1995) aiming to identify the common themes that emerged across the six cases. The analysis of the data and particularly the techniques identified were reviewed by two psychodynamically trained practitioners: one is a clinical psychologist and psychoanalyst/member of the International Psychoanalytic Association and the other a clinical social worker with many years experience in psychodynamic practice (including private practice). The reviewers attempted to identify possible theoretical, methodological, and clinical practice incompatibilities in the detailed process recorded interviews of each case, as well as in the coding and analysis of the respective data in the (Microsoft Excel) tables.

RESULTS

As Stake (2006) noted, the main activity of the cross-case analysis involves reading the case reports and applying the findings of the situated experience to the research questions. The cross-case thematic analysis I performed in this study revealed the themes I encountered (or the techniques I employed) throughout the clinical work with the six parental couples. Those techniques were (1) exploration, (2) clarification, (3) reframing, (4) establishing the setting boundaries, (5) intervention in the environment, (6) confrontation, (7) offering advice, (8) interpretation of the transference to the setting, (9) emphasizing strengths, (10) encouraging the therapeutic alliance, (11) accepting abreaction, and (12) offering education. Below, I present each of the techniques along with "vivid examples" (Brown & Clarke, 2006) of its application throughout the research data. The techniques are presented according to the priority of appearance in the data and not according to their importance or frequency.

Exploration

Through the exploration technique that dominated the assessment phase, I aimed at exploring the development of the child's symptoms as reflected in the psychosocial history of the child and his or her parents. In particular, parents were assisted to realize the way that their own (possibly unwilling) active and passive aggressive behaviors and attitudes toward the child contributed to the appearance of symptoms. In that way they were assisted to limit those behaviors and concurrently increase their supportive stance toward the child—which resulted in the reduction of the SAD symptoms.

The technique revealed that all children had early separation anxiety symptoms before their 6th birthday and all were subjected to parental (particularly maternal) "passive aggression" during the first 2 years of their life. Lina's mother, for example, reported that she "detested breastfeeding

the baby." It was also observed that all parents adopted an overprotective (passive-aggressive) attitude toward their children by treating them as babies and that the maternal pathological behaviors toward the child were indirectly supported by the tolerance of the fathers, who were unable to play their proper part in setting boundaries to the mother–child relationship.

Clarification

I employed the clarification technique to deal with parental defensiveness against realizing one's contribution to the problem of the child. In that way parents were enabled to connect the aggression they had suffered from their own childhood to that they reproduced with their child. As a result, the increased parental supportive behaviors toward the child contributed to the reduction of the child's symptoms.

The application of the clarification technique during the assessment phase enabled me to understand the parental psychosocial development and particularly any form of "aggression" parents might have experienced from their own parents, as well as the way that this aggression went on affecting their current parental functioning. All parents reported adverse childhood experiences; meaning active or passive forms of aggression from their own parents. When aggression appeared to have stemmed from one parent, the other was passively permissive, because he or she failed to prevent it. Maria's mother said "Our father would lock us in the chicken coop ... while my mother would bring us food."

Reframing

During assessment and intervention phases, the reframing technique assisted me to translate the parental narratives through the psychodynamic prism and connect the parental attitudes and behaviors to the emotional needs and behaviors of the child (separation anxiety symptoms), thus indirectly modifying their initial request for the child's therapy into the "therapy of their relationship with the child." I employed the technique to all cases by way of concentrating on the parent–child relationship (parental anger and separation anxiety), the parental emotional difficulties (realization that the emotions that the parents had for the child were the product of their own personal history and experiences), and the couple's own relationship (identification of the aggression between the parents). The application of the technique enabled the parents to connect the quality of parental and couple relationships to the child's symptoms and consequently to reduce their aggression toward the child, resulting in the reduction of his or her symptoms.

When Maria, who exhibited school denial symptoms, finally managed to stay at school and made a phone call to her mother to confirm her

availability, the mother replied "Do you want to leave school and return home?" On this behavior I commented "You seem to unwillingly reinforce Maria's separation difficulty. I guess you have your own reasons for this." As a result, the mother talked about painful separations in her own past and the concomitant anger toward her parents. As might be expected, the use of the technique initially triggered parent resistances (disagreement). Those resistances receded after the parents shared their own psychosocial history and began to connect their own past anxieties with their current behaviors toward the child.

Establishing Boundaries

Through the technique of establishing the boundaries of the setting, I aimed at safeguarding the continuance of the therapeutic setting in assessment and intervention phases. Ways of protecting the professional setting have been my addressing the parents in the formal plural (as in French *vous*, rather than *toi*), as well as my observing of prearranged session time limits (Karpetis, 2010a).

Lina's mother asked me "how are you doing" at the beginning of the second session, and I replied "And you?" As a result, the mother utilized the session to discuss her worries about the child. I presume that whenever we (clinicians) talk about ourselves, we are unconsciously evading the client's problems, thereby returning them to the clients in a more unbearable form. This technique enabled me to concentrate on parental role problems and resulted in the reduction of their aggressive stance toward the child and in the progressive disappearance of the SAD symptoms. I did not employ the technique though in Vasso's case, as I was affected by the maternal emotional difficulties and I prematurely explored her own psychosocial history (transformation of the setting to adult psychotherapy) that resulted in intensification of her resistance to elaborating on the child's problems.

Intervention in the Environment

I employed the intervention in the environment technique during assessment and intervention phases. *Environment* in the current study represents the parental relationship with the clinic and the school, as well as each parent relationship with the environment outside the family (e.g., parental employment). The application of this technique reduced the environmental stressors on the parents, and consequently on the child, bringing about increasing parental supportive behaviors toward the child and the reduction of the SAD symptoms.

During the first session with the parents of Christina, I realized that they had lied to her about the reasons for visiting the clinic. I understood this as

an overprotective parental behavior that reinforced separation anxiety of the child, and I intervened by informing them of the necessity for the child to be aware of the truth.

Confrontation

I employed the confrontation technique during assessment and intervention phases, aiming to disclose the contradictions between the parent's narratives and behaviors, as well as the acquisition of parental insight into the existence of defenses or internal conflicts. In fact, I primarily aimed at overcoming the parental projected aggression (direct or indirect) toward the child, the other parent, or the clinic. In that way, each parent was assisted to realize his or her aggressive behaviors toward the child and accordingly to increase supportive behaviors that contributed to the reduction of the child's SAD symptoms.

Christina's mother, for example, projected her anger on to the intervention team and—although the child's symptoms had been reduced—said during the twelfth session "the child is still afraid but I don't know what of." I replied "You mentioned that you are also afraid to stay at home alone." As a result, the mother was enabled to talk about her own past separation difficulties and progressively understand the way in which her own separation anxiety affected and intensified the fears of the child.

Offering Advice

I employed the technique to help the parents deal with the problems of the child concerning sleep, separation anxiety, sexuality, and homework.

Parents justifiably ask for our advice to handle the difficulties of their child. It is vital, therefore, that we are able and willing to offer advice and subsequently review the way the advice was utilized. Whenever we offer advice, we undertake "a part" of the parental responsibility and become (in the transference) a caring parental figure. Our unwillingness to offer advice—especially during the intervention phase—transforms the supportive character of the setting to that of parent psychotherapy (as parental defenses are dealt with and not their role problems), thus treating the parents as "patients" instead of "partners." The application of the technique assisted the parents to reduce their overprotection and dependency problems toward their child. As a result, the child experienced a more supportive parental stance, which in turn contributed in the reduction of the SAD symptoms.

During the ninth session, Lina's mother asked for my advice on whether she should force the child to do her homework. I replied that to make the school work Lina's own responsibility, the mother could offer her full availability within certain time limits (acceptable to herself) and explain to the

child that she also has to do her own things. At the same time, I suggested that the mother should ask the child about the kind of help that she wanted. As a result, the mother progressively managed to acquire a less intrusive (overprotective) stance on Lina's homework, which in turn contributed to the reduction of the child's separation anxiety.

Interpretation of the Transference to the Setting

When conducting supportive psychotherapy, clinicians employ (although rarely) the interpretation to the transference technique, to enhance the client's adaptive functioning, or maintain the frame of treatment (Winston et al., 1986). The interpretation of the transference to the setting technique (Coren, 2001) is a theoretical extension of "transference interpretation" employed in psychoanalysis and psychoanalytic psychotherapy. The therapist interprets the patient's intense negative or positive emotions toward himself or herself or the institution, as a repetition of emotions unconsciously directed toward the patient's parent figures. In the work with parents, nevertheless, the institutional setting is dissimilar to that of psychotherapy because both parents are present (instead of just the patient); the parental request is for the therapy of the child (not their own); the frequency of the sessions is once a week/fortnight (full transference is not favored); and the work centers on the parents' role (not their own emotional problems) (Karpetis, 2010b).

Intense parental emotions (positive/negative) toward the institution and the practitioner are present at all times, however. The "transference to the setting" notion is derived from object relations theories, according to which transference also contains the client's expectations/wishes from the "object" (Galdston, 1986). Such feelings might appear in the work with parents even during the first meeting, in the form of anxiety over whether the practitioner can be trusted, owing to a fear that he or she might unconsciously and unavoidably represent qualities of his or her own parents. As reported by Malan (1992), the recognition and acceptance of analogous emotions in the "here-and-now" situation strengthens the therapeutic relationship. In that way, elements of "transference neurosis" are developed (for the therapeutic relationship to develop) whereas the development of a full transference relationship is not favored (Ornstein, 1986).

In these sessions, I confined the application of the technique to the understanding of the negative parental emotions toward myself and/or the clinic. For example, during the second parent session Maria's mother reported that the child complained whenever the child therapist inquired about her relationship with her parents. I thought that the mother might have projected onto Maria her own discomfort and resistance to coming to the clinic and replied that "It also might be difficult for you to come to the

clinic; in fact it is quite difficult for most parents." After interpreting those negative transference feelings, both parents confirmed my speculation and replied "We nevertheless come in order to help Maria." The ventilation of those feelings led to the uninterrupted collaboration of the parents (and by extension, of the child) with the clinic; an indication of the increased supportive behaviors of the parents toward the child, which in turn affected the reduction of the child's SAD symptoms.

Emphasizing Client Strengths

In supportive psychotherapy, the clinician needs to continually reevaluate the developmental strengths and deficits of the patient (Misch, 2000). Similarly, the technique of emphasizing the client strengths is an important part of the social work practice identity (Cowger & Snively, 2002) and—like the sharing educational material technique—is an "ego supportive intervention" (Greenberg, 1986). The technique contributed to the strengthening of therapeutic alliance (which is a prerequisite for the improvement of parental behaviors) through focusing on parental strengths. The revelation of "good parental practices" alleviated parental guilt—which was often a byproduct of the parental idealization of himself or herself and/or the child—and allowed parents to seek advice on handling the child's collusive behaviors, thus contributing to the reduction of the SAD symptoms. I employed the technique in assessment and intervention phases centering on each parent's past and current relationship with the child, on the couple relationship, and on the current emotional state of the parent.

When Lina's mother characterized the child therapist's comments on the maternal child overprotection as "excessive" I said that "parents might make mistakes, not on purpose though (meaning unconsciously). In fact, your interest in the child is apparent in your decision to come to the clinic." As a result, the mother asked for advice on handling Lina's separation anxieties. The emphasis on the client's strengths technique necessitated a positive transference therapeutic (relationship) environment. The technique proved effective across all cases and strengthened the therapeutic alliance. I did not employ it, however, in the cases of Maria and Vasso where the parental resistances (passive aggression) to my comments were intense (negative transference). In those cases, I used instead the techniques of reframing, confrontation, and interpretation of the transference to the setting in order to modify the parental "aggression."

Facilitation of the Therapeutic Alliance

Through the facilitation of the therapeutic alliance technique, I intended to convey the message that the therapeutic relationship is a joint endeavor by

both parties/participants. I particularly aimed at establishing the therapeutic alliance through informing parents about the setting and its requirements. At the end of the first meeting, I informed the parents of the need to understand the causes of the SAD symptoms by completing the psychosocial history of the child and of themselves (which was expected to last for about four meetings). I also informed them of the parallel assessment sessions that the child would have with the child therapist, the frequency and the time length of the meetings, and the briefing regarding the child assessment results. In that way, I indirectly named the parents as "partners," resulting in their increased collaboration—which was reflected in the fact that five out of six families completed the assessment phase, during which symptoms were related to the parental aggression toward the child. As a consequence, parents reduced those behaviors and increased their support toward the child, which in turn contributed to the reduction of the SAD symptoms.

The necessity for applying the technique was apparent in Vasso's case, in which I—owing to my countertransference feelings toward the mother—deviated from the setting and initiated an extensive assessment and psychotherapeutic intervention on her own emotional difficulties, apparently against the interests of the child and the urgency of completing the child's psychosocial history. As a consequence, I reinforced the preexisting maternal ambivalence towards bringing the child to the clinic, with the result that the family dropped out of the treatment.

Accepting Abreaction without Interpreting

Via the technique of accepting abreaction without interpreting, I aimed at strengthening the therapeutic alliance through assisting the parents to bear—through identification—painful emotions from their own past. The application of the technique necessitated a concurrent assessment of parental bodily communication. I employed the technique during assessment and intervention phases, and it proved effective in all cases because it contributed to the acquisition of information regarding the parental psychosocial history, the couple's relationship and the parent–child relationship. In that way parents were enabled to connect the problems in the couple and parental relationships to that of the child. As a result, they managed to improve those relationships, thus contributing to the reduction of the child's symptoms.

When the mother of Maria recounted during the fourth session the abusive experiences she had suffered at the hands of her own father, after considering her depressed appearance, I said "those experiences sound very painful." As soon as the mother felt that I could bear her emotional pain, she was enabled to describe more traumatic experiences and progressively connect them to her own behaviors toward the child. As a result, the mother reduced her "overprotective" stance toward Maria that in turn affected the reduction of the child's separation anxiety symptoms.

Sharing Educational Materials

Through the sharing educational materials technique, parents are educated on child and adult emotional development issues and by extension on the causes of SAD. Through this technique, I treated the parents as partners because I shared—on a cognitive level—my "professional knowledge" with them. As a consequence, parents were enabled to think about the emotional aspects (psychic pain) of the SAD and reduce their aggressive behaviors toward the child through identifying with his or her emotional needs, which in turn affected the reduction of the SAD symptoms.

During the third session, after Vasso's mother referred to the serious negligence (passive aggression) that she had experienced from her father, I replied "It sounds as though your father had his own emotional difficulties." As a result, the mother managed to express her enormous anger, by stating "sometimes I wonder how I would feel if my father died."

DISCUSSION

After the analysis of the research data, I was partly able to support the research question because only nine of the 13 supportive psychodynamic psychotherapy techniques were applicable—and potentially effective—in the psychodynamic clinical social work practice with the six parental couples. Those techniques were (1) offering advice, (2) confrontation, (3) intervention in the environment, (4) accepting abreaction without interpretation, (5) emphasis on client strengths, (6) encouragement of the therapeutic alliance, (7) reframing, (8) clarification, and (9) sharing educational material (Table 1).

Nevertheless, I refrained from applying four of the supportive psychotherapy techniques described by Rockland (1989), because they seemed incompatible with the current clinical setting. Those four techniques were (1) giving encouragement and praise, (2) furnishing reassurance and hope, (3) limit setting, and (4) furnishing a model for identification. I particularly felt that the application of the "giving encouragement and praise" technique violates the boundaries of the setting and transforms the therapeutic relationship into a friendly/overprotective one, because the message conveyed to the parents is that we defensively retreat to his or her encouragement and praise because we cannot bear to reveal the emotionally painful causes of his or her anxiety. Additionally, I have not identified the "furnishing reassurance and hope" technique as a separate one, as its content seemed identical to the "emphasis on strengths" technique that vividly elucidates a social work intervention identity. I considered—in line with Greenberg's (1986) view—that the clinician furnishes hope whenever he or she identifies the origins of the parental anxiety as stemming from their past experiences. Moreover,

I renamed the "setting limits" technique as "establishing the boundaries of the setting" to indicate a more extended view of the boundaries of the setting. Likewise, I did not apply the "furnishing a model for identification" technique as I have contemplated that "identification" is a defense mechanism that is hardly transformed into specific parent or practitioner behaviors. Additional reasons (possibly interconnected) that affected my decision to avoid the application of the aforementioned four techniques, I believe were (1) my wish for the development of a scientifically oriented clinical/ social work practice, (2) my professional characteristics as the outcome of my education and practice experience (as described above), and (3) my personality characteristics that unavoidably affect the way I understand and act on my research and clinical practice experiences.

The cross-case analysis through, revealed themes—not formerly described by the supportive psychotherapy model—that constantly emerged throughout the six cases. Those themes/ techniques were (1) exploration, (2) establishing the setting boundaries, and (3) interpreting the transference to the setting. The application of the three techniques, alongside with the other nine, seemed to have contributed to the effectiveness of the clinical intervention with parents.

In evaluating the overall effectiveness of the techniques I employed, it was apparent that they contributed to the effectiveness of the intervention with parents and to the withdrawal of the SAD symptoms (Figure 2) of school refusal, the refusal to separate from the parents, the stomachaches and the nightmares involving separation issues that were present in these cases. Those findings were supported by the child therapist's notes (including the child's point of view) and the parental comments. Whereas in four cases the SAD symptoms of the child disappeared during intervention, in the other two (Andrew, Vasso) the symptoms (refusal to sleep alone, the clinging behavior, and the concomitant fears that the parents may leave) diminished during the intervention and disappeared one year after the intervention ended. In a telephone follow-up $1\frac{1}{2}$ years later, all parents confirmed the effectiveness of the interventions—because all six children were symptom free—and expressed their satisfaction with the cooperation they had had with the clinical social worker and the clinic.

An important instrument that I employed during the intervention has been my readiness to make sense of nonverbal parental communication to (1) identify an incompatibility between their talk and appearance/attitude; (2) verbalize an intense emotion projected in the appearance, stance, or facial expression of the parent; or (3) make sense of a parent silence. An influential in the favorable outcome factor was the work of the child therapist who has managed to increase the children's understanding of the relational causes (in psychodynamic terms) of their separation anxiety symptoms. Another influential in the positive outcome factor was the collaboration between parent and child therapists in the form of exchanging

FIGURE 2 How Techniques Affected the Reduction of the Child's Separation Anxiety Disorder Symptoms
SAD = Separation Anxiety Disorder

information to understand countertransference issues and prevent family drop-out. The detailed examination of those parameters, though, is beyond the scope of this article. Finally, it is also possible that "common factors" (e.g., client, expectancy, therapeutic relationship) might have contributed in the favorable outcome, although the body of the techniques I suggested circumscribes the means for achieving a positive therapeutic relationship.

The socioeconomic status and the educational backgrounds of the six families (Table 2) did not seem to affect the parental responsiveness to the treatment interventions, as the more resisting parents (those who attended the fewer parent sessions) came from lower and middle socioeconomic backgrounds and various educational levels. Although environmental pressures on the parents might have intensified their anxieties, parental emotional factors rooted in their own primary relationships seemed to have been of more weight in contributing to the causation of the disorder.

Limitations

Even though the analysis of the data and the techniques identified were reviewed by a psychoanalyst/member of the International Psychoanalytic Association and a clinical social worker, who expressed no particular disagreements with the way the research data were analyzed and reported, a limitation of the study is that the same person conducted the therapy sessions and the analysis of the data. The recruitment of another psychodynamic practitioner to analyze the same data, in combination with an extensive apposition of his or her training and work experience—according to the practitioner/researcher methodological approach—could further reduce researcher/methodological bias and increase the credibility and trustworthiness of the study.

Other limitations of the study include (1) the practitioner's inability to compare the research findings with analogous research studies in the psychodynamic clinical social work research literature, owing to shortage of similar studies and (2) the only one clinical identity that it studied. Yet the research data are available for researchers to verify the repeatability and therefore the applicability of the suggested techniques. Clinicians could test the research findings for their repeatability and applicability in the field of child and adolescent mental health by using (1) a similar sample, (2) additional raters to increase "trustworthiness" of the data, (3) different types of families, (4) the same and/or different theoretical approaches, and (5) various psychopathology entities.

CONCLUSIONS

In this study, I aimed to contribute to the application of the psychodynamic theory to clinical social work practice, as well as to assist in the reduction of the gap that exists in examining practice-informed research and research-informed practice. I particularly attempted to demonstrate that a treatment plan consists of clinical interventions, or identifiable techniques, which—when applied to clinical social work practice with parents—can be effective for parents and their latency aged children suffering from heightened symptoms of SAD. This coherent body of 12 techniques circumscribed the psychodynamic clinical social work practice and proved effective when applied in work with the parents. I contemplate therefore that those techniques can be useful when applied by psychodynamic practitioners in the child mental health field, and that the clear and measurable behavioral components of which the techniques are constituted, can be helpful for competence-based clinical social work education and practice.

Finally, I suggest a need for social work practitioners/researchers to expose and research their own professional practice to identify and

strengthen its theoretical base, thus contributing to the development of a research-based clinical social work practice theory. Flexner (1915) suggested that such research initiatives are a necessity for our profession to acquire an exclusive and independent knowledge base and a set of transferrable clinical interventions. Clinical practice unavoidably entails the adoption (whether realized or not) of certain theoretical approaches that attempt to explain the causes and treatment of psychopathology. Each (or many) of those theories are inescapably embedded in practice through specific techniques. Research of the way clinical social workers apply those techniques is of vital importance, as they identify and strengthen the distinctive domain and identity of the profession.

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