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PSYCHODYNAMIC CLINICAL SOCIAL WORK PRACTICE WITH PARENTS IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES: A CASE STUDY ON THE ROLE OF THE FATHER

This case study presents a psychodynamic approach to clinical social work practice with the father of a child who suffered from separation anxiety disorder symptoms. The theoretical background of the study is initially presented, followed by a description of the research setting and its participants. The clinician presents his work through critical incidents of parent and practitioner narratives during the assessment and intervention process. The effectiveness of the intervention with the father/parents and the resulting reduction in the child's symptoms appeared to be the consequence of the father's improvement in his role as both parent and husband, which in turn affected positively the mother's improvement in her parent and wife roles. Support to the father's adult part/strengths and the handling of the practitioner's counter-transference feelings were important parameters in evaluating the effectiveness of the intervention.

Keywords father; psychodynamic; clinical social work

Introduction

Even when fathers have minimal contact with their children, they exert a strong influence not only on their social, cognitive and linguistic development but also on their intelligence, academic performance and somatic health (Greene & Moore, 2000; Lamb, 2004). While both paternal and maternal psychopathology form a risk factor in the development of emotional problems in children and adolescents (Connell & Goodman, 2002), fathers are rarely involved when families seek help regarding their children's emotional problems and yet they hesitate to collaborate whenever they are invited (Walters *et al.*, 2001). The mental health practitioners on the other hand, tend to exclude them from the child therapy process (Duhig *et al.*, 2002). Finally, it is reported that fathers are usually absent as single research subjects in the developmental psychology, since they represent only 2% of the published studies (Phares *et al.*, 2005).

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In the psychoanalytic literature, there is no comprehensive and cohesive theory about fatherhood (Etchegoyen, 2002). Historically, Sigmund Freud (1913), Ferenczi (1931) and Abraham (1913) presented the father as an important figure for the child's emotional development. They stated that the castration threat on the child's incestuous oedipal wishes represents the demands of reality on the ego, bringing about the resolution of the Oedipus complex, from which intrapsychic energy is freed and displaced onto creativity, relationships and learning.

After the Second World War and the advent of the object relation theories, psychoanalysts were mostly interested in understanding the early mother-child relationship. Melanie Klein (1932) stated that the oedipal conflict was shaped by the child's early relation to the breast. The father was seen as a part-object in the mother's body that the children faced with rivalry and jealousy, due to the mother's possession. During weaning, those unconscious emotions bring about persecution and guilt towards both part-object parents. With the advent of the depressive position, the mother is gradually recognized as a whole object (separate) allowing for the child's separate relationship with the father, with whom the child is about to negotiate his ensuing castration anxieties (Etchegoyen, 2002).

Winnicott (1958) noted that the father's role in early childhood is to support the mother in order for her to provide a holding environment. Bowlby (1982) added that the father prevents the mother from feeling overwhelmed by the needs of the child.

Mahler (1971) noticed that the father facilitates the 'separation-individuation' of the mother-child dyad through providing a stimulus for early exploration, as well as through protecting the child against a regressive symbiotic pull to the mother. Abelin (1975) expanded Mahler's thinking and elaborated on the 18-month-old child's experience of the existence of the parental couple, which is both traumatic and organizing, as it encourages a developmental move towards a symbolic representation of the triangulated relationship.

Lacan (1949) propelled the reappearance of the father in psychoanalytic literature during the 1970s. Although he shared Freud's view on the importance of the Oedipus complex, he maintained that the symbolic castration and prohibition against incest that the father imposes on the mother-child union, boosts the child's symbolic thought together with the development of his language and socialization (Etchegoyen, 2002).

Kohut (1984) pointed out that the fathers who are able to empathize with their children, supply them with the sufficient mirroring, a prerequisite for the acquisition of a cohesive self. He additionally noted that the need for a loving father is universal.

The father has an important role to play in recent psychoanalytic thinking, in which the Oedipus complex is not so much seen as the nucleus for neurosis, as the nucleus for normal character structure and mature life. Now, the main developmental issue is the child's recognition and acceptance of a mutually enjoyed and creative parental couple sexual relationship, which operates as an organiser of the child's perception and thinking (Etchegoyen, 2002).

Recent studies in the attachment research field indicate that the father can exist as an attachment figure alongside or independent from that of the mother. The child accordingly, could be securely attached to one parent and insecurely attached to the other. Finally, it is reported that the child's security of attachment is affected by the representation that each parent has of his own attachment history (Target & Fonagy, 2002).

In the present case study, the practitioner attempts to delineate the psychodynamic clinical social work practice with a parental couple – mainly the father – who requested treatment in a Child and Adolescent Mental Health Services (CAMHS) clinic, regarding the separation anxiety disorder symptoms of their latency aged child. The theoretical background of the study is initially portrayed, followed by a description of the research setting and its participants. The intervention process is accordingly described in the form of critical incidents through parent and practitioner narratives, which are expected to enlighten the father role during the assessment and treatment of the child's disorder, as well as the effectiveness of the intervention with both parents and, by extension, with the child.

Theoretical background of the study

The theoretical background, on which the present study is founded, includes references from clinical social work, the psychodynamic understanding of parenting and separation anxiety disorder and the case study research method.

As defined by the American Board of Examiners in Clinical Social Work (ABECSW, 1995), clinical social work is a practice specialty in social work that builds upon generic values, ethics, principles, practice methods, and the person-in-environment perspective of the profession. Its purposes are to (i) diagnose and treat biopsychosocial disability and impairment, including mental and emotional disorders and developmental disabilities; (ii) support and enhance biopsychosocial strengths and functioning; and (iii) achieve optimal prevention of biopsychosocial dysfunction. Clinical social work practice applies specific knowledge, theories and methods to assess and diagnose, plan treatment, intervene, and evaluate the outcome of the work with individuals, families and small groups. Clinical social work practice particularly assesses the biopsychosocial dimensions of mental health disorders that affect client social functioning and intervenes in the internal dynamics of the client (aiming to strengthen the client's ego and his interpersonal relationships), as well as his immediate social network. For clinical social work, the practitioner-client relationship is considered to be both an assessment tool and an agent of change (Strean, 1996). Clinical social work practice in CAMHS primarily focuses on the assessment and treatment of parenting problems.

Parenting on psychodynamic terms, is the way with which parents apply their relational and educational skills to their children, as well as the way in which parents represent and experience their own fantasies, conflicts and internalized relationships. The way a parent unconsciously projects parts of himself onto the child is called projective identification, while the parental role subsequently undertaken by the parent is called complementary identification (Muratori *et al.*, 2002). The frequency and extent of the projected parental images onto the child, determine the extent to which parents behave like their own parents. As noted by Davids (2002), those images are the outcome of the unconscious internalized experiences of each parent's own fathering and mothering and contain the early experienced parents of splitting, the more real/whole parents of the depressive position and finally the oedipal parents. The projected parental images –or 'aggression' according to Rustin (1998) – are thought to produce the symptoms of the child.

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 behaviours and attitudes (passive or active, direct or indirect, conscious or unconscious) towards the child. More specifically, the objectives are (i) the revelation of the causes of the child's symptoms; (ii) the understanding of those parental behaviours and attitudes that enhance child psychopathology; (iii) the safeguarding of the uninterrupted parental participation in the child therapy process; (iv) the enhancement of the parents' and (through them) the child's motivation for engagement into the therapeutic process; and (v) the enhancement/strengthening of the supportive parental roles (Karpetis, 2008).

According to Anna Freud (1966), the cause of separation anxiety disorder is the unconscious aggression that the mother/parents direct toward the child, to whom intense 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 experiences intense anxiety due to his anger for their actual or impending departure (for example, school phobia symptoms). Bowlby (1960) added that another cause of separation anxiety is the threat of loss of love that parents use in order to preserve their pathological attachment to their child.

Klein (1936) explained 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 good breast during weaning. Later on, oedipal loss subsumes the 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. With the help of a containing mother, the child is consequently able to tolerate the concomitant feelings of grief and ambivalence towards the relinquished object, as well as the damage that is felt to have been inflicted upon her (Barrows & Barrows, 2002).

The 'case study' term originated from the 'casework' of doctors and social workers in the late 1800s. Progressively, it was differentiated from its therapeutic connotation and became an important social science research method that allowed for the application of a theory to the research plan and data analysis. Case studies are useful in answering 'why' and 'how' questions and provide a holistic view of the research process (Midgley, 2006). Hans Eysenk (quoted in Flyvbjerg, 2006, p. 224), an advocate of quantitative research and a former opponent of the case study method, noted in his later writings: 'sometimes we simply have to keep our eyes open and look carefully at individual cases, not in the hope of proving anything but rather in the hope of learning something'.

The clinical case study is a type of psychological research method that appeared in 1895, when Freud and Breuer (1952) published *Studies on Hysteria*, and it was extensively used until the 1930s (when quantitative research dominated the research field until the 1980s). From then onward, research methodology pluralism resulted in the dynamic return of qualitative methods and the reappearance of 'case studies' in the social and health scientific literature.

The intentional sampling in case studies aims to acquire rich information and in-depth knowledge of the case, rather than sample representativeness, generalization of results and the so called 'objectivity of the researcher' (Eisenharrdt, 1989). Devereux (quoted in Giami, 2001, p. 5) questioned the 'objectivity of the researcher',

stating that the researcher is also observed by the research subject. He further noted that in order for knowledge to be generated, any research methodology tool should contribute to the reduction of the researcher's anxiety. He labelled 'researcher countertransference' as the researcher's bias toward the research subject, the research tools, and himself. Those biases appear in both qualitative and quantitative research and (apart from being an impediment) they can enrich the research endeavour. In the clinical case study, the unavoidable researcher bias can be overcome through (i) anamnestic process recording right after the ending of each session (Klein, 1961); (ii) clearly stating the speaker when quoting session narratives; (iii) describing non-verbal client communication; and (iv) reporting the thoughts and the countertransference of the practitioner (Klumpner & Galatzer, 1991).

Spence (cited in Midgley, 2006, p. 131) maintained that in the clinical case study the research subject is the practitioner himself, as he represents the intervention itself. The research data includes archives, interviews, questionnaires and observations (Meyer, 2001). Shaw (2005, p. 1241) called 'practitioners-researchers' those social workers who conduct research on their own practice and at the same time devote 80% of their working time in direct practice with clients.

The research setting

The main components of the case study research setting were the institution (CAMHS), the practitioner-researcher, and the case under study (the parents). The way in which they affected the intervention and its outcome will be presented below.

The CAMHS clinic interdisciplinary team is approaching its clinical practice assured that work with parents is a prerequisite for achieving therapeutic results. In fact, when there is no collaboration with parents, the assessment of the child does not begin (Reeves, 1988; Lush, 1998). Parent work has the characteristics of psychodynamic clinical social work practice (Karpetis, 2008); accords equal importance to the participation of both parents and takes place on a fortnightly basis. Families are referred to the clinic by educational, health and social service agencies. A parent/guardian is expected to call and provide initial information about the child's problem. An interdisciplinary team meeting ensues; a practitioner (usually a psychologist or a child psychiatrist) undertakes the assessment of the child while the clinical social worker assesses the parents. The psychosocial history of the child and his parents and the resulting assessment of their parenting problems offer an initial picture of the causes and the contributing relationships in the child symptomatology. Both parent and child assessment led to proposals on the work needed for the child and his parents. The assessment results are then discussed with the parents in a separate meeting, in order for them to agree on any suggested intervention.

Since the practitioner is both a part and medium of the case study (Fook, 2001), his training and professional experience are expected to have influenced the effectiveness of his work. At the time of his intervention, the practitioner was a postgraduate in social work; has acquired training in psychodynamic social work practice at the Tavistock Clinic (London) and has completed an introductory training in child psychotherapy (2-year psychoanalytic baby observation and 5 years of personal psychoanalysis). He had a 4-year full-time work experience with parents in a

deinstitutionalization hostel for physically handicapped and/or emotionally disturbed children, a 5-year full-time work experience with parents in a CAMHS clinic and a 10-year part-time work experience with parents in a therapeutic unit for psychotic and autistic children. All scientific directors of the above workplaces were psychoanalysts or training psychoanalytic child/adult psychotherapists.

The parents of 6-year-old Christina had been married for 13 years. The 39-year-old father was a public servant working night shifts. The 29-year-old mother was a housewife. Both parents were primary school graduates and they grew up in poor, rural farming families. The 12-year-old brother of Christina was a secondary school student. The family was living in a rented apartment and they were burdened with financial difficulties. The parents participated in 18 fortnightly sessions (either the mother or the father alone or both parents) with the clinical social worker.

Christina's case

Both parents arrived for their first appointment on time. The mother had a depressive manner and the father seemed defensive (he smiled, rather confused). The mother said

> Christina is unable to separate from me . . . during the last year, she was crying every day in the nursery . . . now she wakes up every night crying and comes to our bed and when we send her back, she would stand still and cry all night long . . . some days she doesn't want to go to school.

The father said that he had no problems with his daughter, apart from her waking up at night. The mother accused the father of spoiling the child, since he disagreed (in Christina's presence) with any disciplinary measures she would take. The mother linked the appearance of Christina's symptoms to her bronchial asthma and to an earthquake that occurred four years ago. At that time, the parental couple had serious marital problems, since the father verbally and physically abused the mother in Christina's presence.

At this point, the practitioner initiated a risk assessment (Doctor, 2004) of the father's past violent behaviour. He acquired information on the severity, intensity, frequency, duration (Enns *et al.*, 1997) and generality (Huss *et al.*, 2006) of the abuse, as well as on the overall psychosocial adjustment and any protective factors operating for both the father and the family (Huss *et al.*, 2006). It appeared that the mother was physically abused over a period of about a year, four years ago, and that arguments were still happening between the parents at home. The practitioner accordingly decided to (i) inform the child therapist and the rest of the interdisciplinary team members (Miller *et al.*, 2002) on the issues encountered; (ii) engage the father in the child therapeutic process (Hilton & Harris, 2005); and (iii) further assess the father's personality for probable severe psychopathology indicators that might lead to recidivism.

During the same first meeting, the mother projected the child's problems onto the father, who appeared to deny, rationalize and hardly empathize with Christina's emotional pain. Both parents were unable to associate Christina's symptoms with the crisis in their own relationship. The practitioner, urged by the depressive picture of the

mother and the defensive attitude of the father, attempted to support the mother through pinpointing the pain inside her. He said 'the situation must have been very difficult in the past and the mother seems to have felt many times loneliness inside her'. The mother agreed, relieved and the father smiled, rather embarrassed. The practitioner offered another appointment to the mother and informed the father that he would see him afterwards. Still, he did not offer him another appointment as he was unconsciously driven by his own countertransference feelings (anger for the mother's abuse). In fact, he ejected the father from the collaboration, since, at that time, he was unable to recognize his caring (positive) parenting part (he came to the clinic in order to help his daughter).

During her first session with the child therapist, Christina was unable to separate from her mother and confirmed the past parental fights. She also noted that she was still afraid of her father but less of her mother. During her next session, the mother said that she would take Christina to sleep in her bedroom, otherwise she would cry a lot. The practitioner realized that the mother accelerated Christina's separation anxieties; he therefore inquired about the father's role in the mother-child relationship. The mother described the father as a passive participant in the child-daughter separation difficulties. The practitioner thought that the father was unable to set boundaries, as he 'tolerated' his wife's sleeping habits with his daughter. In fact, he moved to another room. Yet, the father projected his own inability onto his wife, and blamed her for Christina's problems. Likewise, when the practitioner asked the mother if it was convenient for her to sleep with Christina (since in that way she managed to avoid her husband), she hesitatingly agreed, thus confirming her own contribution to the child's separation anxiety problem.

The exploration of the child's problem in relation to the couple relationship (apparently against the mother's expectations), along with the practitioner's indirect exclusion of the father at the end of the first session, appeared to have triggered parental defences. Christina failed to show up for her next appointment and rejected any collaboration with her therapist, who noted '... work with parents is needed in order for the child to show up'.

Similarly, the father did not appear for his next appointment (offered to him through the mother); neither did he call for a cancellation. During the following session, the mother said that the father did not want to come to the clinic and that Christina's separation anxiety behaviours were reduced, as it was much easier for her to sleep alone (despite her waking up at night). This temporary improvement seemed to have been the result of the practitioner's former advice to the parents regarding the necessity to set boundaries on the child's sleeping habits. The practitioner avoided any further comment on the father's attitude, since he intended to invite him with a letter. Instead, he asked the mother's help '... in order to acquire Christina's developmental history and therefore understand her current need to wake up at night'.

The mother talked about her agony on her child's bronchial asthma, the violent separation of Christina from her dummy (the mother had put pepper on it) and the serious problems in the parental couple relationship. The mother also reported that, because she was working, the father used to babysit Christina until she was 3 years old, during the afternoons. When the mother said, '... he was waiting though for my return at home in order to go to the pub', the practitioner, in recognizing the father's role in caring part for the child as well as both parents' need for personal time (in fact 'separation'),

replied that "the father might needed to go". This intervention resulted in the mother's comment that the father had followed the practitioner's suggestions (the mother had informed him) and bought a doll for Christina in order to assist her sleeping during the night. The practitioner commented that 'the father, despite his absence from the parent sessions, was interested in the practitioner's suggestions, which he transformed into actions of care for the child'. During the same session, the practitioner went after a more extended risk assessment (regarding the past violent behaviour of the father), from which the interdisciplinary team members concluded that there was a low risk possibility for paternal recidivism (Kropp, 2004).

The father failed to show up for his appointment. During the following session, the mother said in a conspiratorial manner 'my husband did not tell me anything about the letter you sent him ... he either did not get it or had hidden it'. The practitioner replied that, 'the father might have felt shame, as painful issues about his relationship with you were elaborated on during our first meeting and he might be afraid that he will be accused again'. The mother replied that she intended to inform the father concerning the thoughts of the practitioner, who indirectly consented since he purposely avoided any further comment. The maternal positive acceptance of the practitioner's comments appeared to have been the result of the practitioner's attempted reparation of the father's indirect exclusion from the sessions, the realization of the father's positive parenting part, the depressive/guilty personality structure of the mother, and the therapeutic relationship (positive transference feelings) established.

Following that session, Christina requested to meet her therapist who afterwards noted 'I saw Christina alone ... calm, she was feeling safer and less fearful ... all family members seemed less anxious'. During her next appointment, the mother said that, 'Christina is much calmer and not so negative with me ... even more I can talk with my husband about everyday family issues'. The temporary improvement of the child and the parental couple relationships was possibly the outcome of the therapeutic relationship that the parents developed with the practitioner, of the increased care (reduction of the aggression) that the child received from her parents, and of the reduction of the tension in the couple's relationship. Yet, the father's absence from his sessions still reflected a passive aggressive attitude towards the child, because his interest for the child should have ideally prevailed over any anger he might have for the practitioner regarding his former ejection from the parent meetings.

Subsequently, the practitioner sent a letter to the father offering another appointment. The father came and stated that he did not receive the initial letter. He repeated that Christina was doing much better at home, due to the clinician's advice on her difficulties in sleeping. At this point, the practitioner (while complementing Christina's psychosocial history) said, 'I know from my discussion with your wife that while she was working you looked after Christina'. The father, apparently relieved (bodily communication), said that he might have caused Christina's problem as he spoiled her, because he is very sensitive towards children. The practitioner thought that the emergence of the father's guilt (despite his repeating the accusations for the mother) disclosed a positive parenting part and a wish for reparation. This part of the father came to the surface right after the practitioner was able to think about his own countertransference feelings and attempt reparation. The clinician subsequently asked the father to talk about his personal history, in order for him to understand his

'sensitivity towards children' that might have triggered his inability to set boundaries for Christina, as well as his violent (abusive) part.

As a result, the father disclosed emotionally painful events of his personal history (an indication of the therapeutic alliance created). He talked about his anxiety regarding his low-paid job and the concomitant financial problems of the family, as well as his considering that a possible solution might be the family's relocation to his hometown. The father is the eldest of three brothers. He had an idealized picture of his 'strict' father: 'he would send me to work in the farm, even during my final exams at school' and justified his aggressive attitude, 'I was very close to him'. He admired (idealized) his farmer mother, whom he described as very energetic with compulsive personality characteristics. At school, he was not much interested in his studies (his grades were average) and he seemed rather proud of himself when he recalled bullying his classmates. After his primary school graduation, he worked on the family farm until he was 18, when he fell in love with a girl. Three years later, they moved to the capital city (despite the expressed sadness and disagreement of his father) and they lived together. She quickly abandoned him 'because he could not find a job as a public servant'. A month later, he followed his parents' advice and got engaged to an adolescent girl (his current wife) from his hometown (perhaps an unconscious avoidance of the pain of abandonment, as he did not mourn his former relationship). A year later, they were married and moved to the capital. From then onwards, the father had two jobs (one as a public servant) in order to meet the financial needs of the family.

At this point, the practitioner asked the father if he was referring to the same period that the mother had talked in relation to their marital problems. The father thoughtfully agreed and defensively added that his wife had disagreed with the plan to move the family back to their hometown, although she currently supported this plan. The practitioner made the above comment as he intended to (i) help the father face the pain of his violent behaviour and its associative shame (Lohr *et al.*, 2006); (ii) to communicate to the father that he could withstand his painful abusive part and the ensuing shame and guilt and still have a collaborative/therapeutic relationship with him; and (iii) complement the risk assessment through understanding the internal meaning (Doctor, 2004) that violence had for the father.

During her next session, the mother said 'my husband is not so nervous any more . . . there is an understanding . . . what I always wanted . . . he was probably helped by the discussion with you; he was very worried before his appointment, but very calm afterwards . . . who knows?' and added that she herself was also helped, because 'you told me not to sleep with my child and that it is not bad for my husband to go to the pub'. The practitioner assessed that the father's change was probably the after-effect of the 'containment' (Bion, 1962) of his guilt and that through the process of reviewing his psychosocial history, he had the chance to see how marital strife (that affected the child's problem) was related to his past relationships and current problems.

During the following two meetings, the mother talked about her own separation anxiety from her overprotective parents (she characterized her father as 'good' and her mother as 'irresponsible'), about her refusal to marry her husband (she did it for her parents' sake), and her loneliness and sadness after the marriage: 'I was pregnant and

I was crying for my mother'. She also referred to a current sexual problem with her husband and to the anger at being abused by him in the past.

In the next session, the father confirmed Christina's improvement stating

> she is much calmer . . . she likes going to school . . . she goes to sleep alone. You should see our former situation. I had to wake up for work at three in the morning and I was sleepless, as Christina was crying and pushed me away from bed . . . now I am thinking of buying her a new bed.

He also expressed his belief that Christina had improved due both to his wife's help and to the clinic.

During the following session with the mother, the practitioner continued the assessment process and acquired the mother's psychosocial history, which apparently rekindled her own fears, separation anxieties and suspended anger towards both her father and husband. She said, 'memories of my childhood come to my mind lately . . . things that I forgot . . . I remembered that my father smacked my mother and she bled'. The mother's anger though took a compulsive form, as she said, 'I sometimes have the fantasy that I will be cut by a broken bottle'. The practitioner connected her fears and anxieties to her suspended anger towards her relationship with her husband, which in turn affected the problem of the child. The mother consequently reported the practitioner's thoughts to the father, 'I told him everything and he didn't get mad, instead he was listening carefully'. At the same time, the mother noted that the sexual relationship with her husband had improved and that Christina's separation anxiety behaviours seemed to have disappeared.

From this point onward, the father's role as a husband drastically altered and he 'allowed' the mother to go to the cinema with her friends (for the first time in her life). The mother said, 'I told him let's go together, but he postponed it . . . .I like going out with him, he is my husband . . . .I told him I will never again go on vacation alone with the kids . . . neither the kids nor I like it.' She also said that she understood the importance of a good relationship with her husband and the positive effect it has on the children. She said, 'I do not react spasmodically any more, I do not shout, I explain to my husband how I feel and how I expect him to help me . . . because I have changed, my husband also changed, and he is much more supportive'. In particular, she described an incident where she expressed in an explosive way her anger towards the father (regarding his compliance towards Christina) and he replied in a supportive manner, 'Don't shout, your health will suffer'. In the same period, the mother began looking for a part-time job to help minimize the family's financial difficulties. Both parents started to have social relations with other parents from Christina's school. Those parental behaviours were indicative of improvement in the parent role (reduction of passive and active aggressive behaviours towards the child) and both parents' social functioning.

During a follow-up telephone call a year and a half later, the mother said that Christina had no separation anxiety symptoms ('she sometimes sleeps at her friends' houses') and that she was a very good student. All family members were doing well and the mother was working part-time. Both parents were very satisfied (the mother said 'grateful') with the clinical social worker and the rest of the clinic staff.

Conclusions

Clinical social work practice with Christina's parents revealed the way that the father contributed to the initial appearance and later absence of the child's separation anxiety disorder symptoms, as well as the way that clinical social work practice helped the father acquire a healthier parenting role, which in effect contributed to Christina's therapy.

The main contribution of the father to Christina's problem was his inability to protect her from being a spectator of the past parental abusive relationship. Christina's separation anxiety symptoms possibly reflected the child's attempt to protect both herself and her mother from further parental violence. The ensuing long-lasting crisis in the marital relationship together with the personality characteristics of each parent seemed to have preserved Christina's symptoms. The violent part of the father, which was possibly the product of the pervasive, emotionally traumatic childhood he experienced in his own family (Lohr *et al.*, 2006), contributed to his own 'separation' difficulties. He unconsciously experienced his wife as an impediment to his return to his hometown (his own mother). His violent part was further accentuated by alcohol abuse (dependency problems), the extreme passivity of the mother and of the tension that the financial problems produced in the family.

The father in addition, was unable to set boundaries with the child (he was overprotective and unable to say 'no') and refrained from intervening in the pathological mother-child relationship (allowed them to sleep together). In fact, he was not supportive of the mother with regard to her mothering role. Since parental behaviours and attitudes are unconsciously affected by the internalized experiences of each parent's own fathering and mothering (Trowell, 2002), the paternal 'sensitivity to children' was possibly the outcome of the 'aggression' (physical or emotional abuse) that the father received from his own parents. Whenever the father used overprotective behaviours towards Christina, he denoted his determination to be different from his own parents. Additionally, his inability to work through his own losses and the ensuing ambivalent feelings (regarding his attempts to separate from his own family) influenced Christina's capacity to face loss/separation from her parents. Attachment research reports that the father's 'ghosts' (internal images of his own parents) have a powerful impact on the emotional development and clinical presentation of children (Barrows & Barrows, 2002).

The intervention helped the father to improve his parenting role and facilitated the reduction in Christina's symptoms. The father managed to participate in the child's therapeutic process and despite his temporary absence from the parent sessions, he was willing to start thinking about painful parts of his personal history that affected the relationship with his wife (Hilton & Harris, 2005), as well as about his contribution to Christina's problem. He managed to use the therapeutic relationship and reduced his overprotective behaviour towards the child, thus contributing to the improvement of the couple relationship, by means of withstanding the mother's anger regarding his past abusive behaviour. The improved couple relationship in turn reduced the mother's emotional overinvestment in the child that was formerly enacted through separation anxiety-provoking behaviours.

By reviewing the paternal psychosocial history, the practitioner worked through his earlier losses (Barrows & Barrows, 2002) and indirectly helped the father to initiate

the process of connecting the aggression and the painful separations of his own family with his current relationship to his wife and daughter. After the 'containment' of the father's aggressive role and its associated shame (Lohr *et al.*, 2006), the paternal 'anger/separation anxiety' became more manageable and allowed for the predominance of caring feelings for his wife. As a result, he was able to tolerate his own unresolved past separation anxieties better, as well as his wife's anger regarding his past abusive behavior. Both parents were accordingly able to emotionally reinvest in their relationship to the child. As a result, the intensity of Christina's ambivalent feelings and (with the child therapist's interpretative help of the child's anxieties) the feared 'damage' inflicted upon her parents, were reduced.

The study revealed that the psychodynamic clinical social work intervention and especially the 'coalition' of the practitioner with the parental adult/mature part, or otherwise 'client strengths' (Cowger & Snively, 2002), was effective with both the parents and indirectly the child. The practitioner focused his interventions not on the emotional problems of the parents but rather on father and mother parental roles. After all, they asked for treatment of their child and not of themselves. Whenever individual problems of the father or of the parental couple relationship were discussed, they were always connected to the child's symptoms and the subsequent parental role behaviours.

The study also indicated the way that the countertransference feelings of the practitioner excluded the father from the therapeutic process. On a negative transference level, the practitioner temporarily became an emotionally depriving father figure, who re-enacted the neglecting/traumatic parts of the paternal father. The family symptom of ejecting the father out of the 'marital bed' was also re-enacted, since the practitioner symbolically repeated the mother's behaviour towards the father, which in turn negatively affected Christina's relationship to the father. As noted by Marks (2002), the mother's internal image of the father role (a by-product of how she experienced her own father, as mediated by her own mother) affects the way that the child will relate to his/her own father.

The practitioner was able to involve the father in the therapeutic process in a reparative way, only after he was able to realize that both parents equally contributed to the development of the child's symptoms and that, despite the initial serious problems in their relationship, they went on living together and actively or passively had contributed to an 'aggressive' relationship with the child. Since the parental couple relationship ideally entails the joint responsibility for the child, one could hardly blame only one parent for causing the child's problem, since the other (actively or passively) 'permits' or 'tolerates' it.

The family could be seen as a defensive organization, according to which each parent has unconsciously chosen the other in order to fit with – and enact – his/her own projections (Bower, 2005). The father – through projective identification – was unconsciously projecting his own vulnerability to the mother and the mother was projecting her own violence/aggression to the father, whereas Christina – through her separation anxiety symptoms – was a receptacle for both parents' own unbearable emotional states. In working with the parents, the practitioner received and processed – therefore contained – those projections, as he assisted the father to enhance his understanding of his dependency needs and the mother to realize and deal with her own aggression. As a result, the child was freed from those projections and ceased

to unconsciously assist (for her own reasons, which were dealt with by the child therapist) her parents in order to hide their own problems behind her symptoms.

The practitioner's functions (attitude) of caring, thinking, clarifying, differentiating, naming a vague feeling and connecting it to something meaningful, mirror qualities of healthy parenting (Saltzberger-Wittenberg, 1970). On a transference level, the practitioner concurrently represented (unconsciously became) for the parents both a 'parent' and a 'brother' figure. As a parent, he provided the aforementioned qualities of emotional care as well as boundaries; and as a brother he openly discussed with them his thoughts on their parenting mistakes and offered his advice (Karpetis, 2008).

Finally, the study indicated the need for practitioners to encourage the father's participation in the child therapy process. The practitioner offered more sessions to the mother rather than to the father, because there was an urgent need for the mother to deal with her own emotional dependency needs that apparently reinforced the child's separation anxiety symptoms. Even then though, the father was always present in the practitioner's talk and his role was valued as critical in the process of understanding and dealing with the problems of his child and his wife.

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