20/11/02

The Problem of the Referring Person*

Mara Selvini Palazzoli**
Luigi Boscolo***
Gianfranco Cecchin***
Giuliana Prata****

This paper is a preliminary contribution to the potentially insidious problem of the referring person in family therapy. In our experience, our failure to examine this problem according to the systemic epistemology was the root of several unsuccessful therapies. A description of those who, most often, are the referring persons to be suspected of having become homeostatic members of the family is given. We also present sketches of the behavior we most often observe in families which are maintaining a homeostatic bond with the referring person. Lastly, we explain and give examples of the tactics devised by our team to reveal and resolve this problem.[1]

The problem of the referring person in family therapy is one of the most insidious and potentially compromising to the success of treatment. However, this problem is overlooked in the literature dealing with family therapy; we have not been able to discover more than its merest mention in publications made to date. During workshops and seminars we have noted occasional allusions to a "hostile referral", but in these cases we are dealing with no more than sporadic observations, and, while they demonstrate a certain awareness of the existence of this problem, they do not show the full appreciation of its gravity which would lead to a detailed analysis.

We carried out our research in family therapy for years without paying particular attention to this specific problem. Even while being aware that in certain cases the referring person could constitute a grave problem, and even after establishing (in 1972) that on every family's chart, the first question should be, "Who referred the family?", we continued to regard the referring person according to the traditional model, considering above all his rapport with us and underevaluating that which he had with the family.

But certain failures in therapy forced us to go over entire cases in an effort to discover where we had gone wrong. We were able to understand that our error was very basic; we had failed to build our study of the family upon the systemic model in that we had been dealing with a family that was missing one of its members who occupied a nodal homeostatic position in that family, the referring person. Therefore the essential question which we should always ask ourselves is, "What is the present position of the

*Translated from Italian by Elizabeth V. Burt, Milan

**Mara Selvini Palazzoli, M.D., is founder and Research Director of the Milan Center (Centro per lo Studio della Famiglia, Via Leopardi 19, 20123, Milano, Italia)

***Luigi Boscolo, M.D., is a member of the research team and co-director of training at the Milan Center.

***Gianfranco Cecchin, M.D., is a member of the research team and co-director of training.

****Giuliana Prata, M.D., is also a member of the research team.

referring person in the family group? Has he/she become involved to the point of becoming an important member in the family system?" Our failure to consider him/her as a member of the family was further aggravated by the fact that the referring person, in not participating in the session, had the power of the 'absent member' (Sonne, Speck, & Jungreis, 1965).

The problem of the referring person, which may occur in every type of family, reaches the maximum frequency and the maximum insidiousness when we are dealing with families presenting psychotic patients, particularly, those characterized by the type of communication defined as schizophrenic. We observed that in such families there is a certain "stickiness" that characterizes the various relationships. Wynne and Singer, in their classic work on the disorder of communication in the families of schizophrenics, were the first to observe this phenomenon and speak of it, coining the splendid metaphoric expression, "rubber fence". The "rubber fence" is something that encircles the family, something which absorbs anything or anyone who ventures near it (Wynne and Singer, 1963; 1965).

The professional who assists the index patient belonging to such a family is particularly exposed to this phenomenon. If he passes the family's "entrance exam", the rubber fence silently swallows him whole and he becomes installed in the position of a full-right member of the family. As such, he looses any operative possibility. Not only this, but having become a member of a family characterized by a highly homeostatic tendency, he will become, paradoxically, an essential prop to the family.

The individual who is absorbed unknowingly by the family commonly passes through three stages. First he experiences gratitude and fulfillment for having been welcomed by the family as its helper. However, bit by bit, as all his efforts and urgings towards change in the family go unheeded and, as at the same time, his endeavors are met by subtle disqualifications from the family, he will enter into the second stage which is characterized by a growing sense of discomfort and uneasiness, by the vague sensation of being trapped. Thus, in the third stage, pushed to exasperation and seeking some solution, he sends the family to family therapy. We can describe these stages because, in our professional careers, we ourselves have had this experience, and are sure that anyone who has worked with schizophrenic families can confirm it.

The reaction of the family bundled off to family therapy is usually one of total obedience. The referring person has become essential to its homeostasis, and he must be kept as a member of the family at all costs. The family will do anything to please him, anything apparent, that is. If the family therapist inquires into the motive which has lead the family into therapy, he will usually receive the following stereotype, redundant answer: "Well, we've tried everything else, we might as well try this too." Implicit in this answer is the certainity, "If everything else has failed, this will too." However, after going to family therapy, they will be able to return to the referring person, their consciences appeased, with an apologetic smile on their lips, in order to resume their idyll where they had left off.

As stated above, the problem of the referring person may occur in the most diverse types of families, though it may be less insidious and take place with less frequency in families other than those of the schizophrenic type. Therefore one must consider its possibility in all cases and gather accurate information in this respect.

What Type of Referring Person is Most Suspect

Those who are most commonly susceptible to becoming homeostatic members of the family and are therefore the most to be suspected are:

a) Child psychiatrists, neurologists, pediatricians and family physicians who have

been treating one member of the family for years, and have ended up by forming a friendship with them.

b) Young psychiatrists and psychologists, so-called "supportive" therapists, who have become involved with the family of the patient, most often with the mother, who maintains contact through long telephone chats, special requests, and invitations. In this case, it is almost always the young therapist who contacts our center, or else comes personally, with notable anxiety and embarassment, usually without an appointment, to present his case.

c) More rarely, social workers who are assisting a chronic psychotic or are acting as middlemen between the patient and the family and the patient and the eventual clinic to which he is sent.

How do Suspect Families Behave?

Through observation and careful examination of the relationship between the referring person and the family, we have come to note that when the former occupies a homeostatic position as a member of the family, the latter often displays three different types of behavior patterns in the session which can be sketched as follows:

a) *The smiling family:* This is usually a courteous, good-humored family, without the least anxiety in spite of the poverty of its present relational situation and the serious condition of the index patient. Its analogical message seems to be, "Here we are at your complete dispositon, now what can we do for you?" This attitude may remind one of the smiling cheerfulness and generic helpfulness of the expert public relations person. The information supplied by the family is just as generic in that it gives us nothing meaningful. This type of family had adapted itself to the index patient, who is more of a problem for the referring person than for his family. This family is the most able in sucking in whomever approaches it. A family of this type, which presented as the index patient a daughter who had been diagnosed as hebephrenic from the age of ten years, had maintained a close friendship with the referring psychiatrist for years. The young psychiatrist had been a guest in the family's home for long periods of time. During the session with this family, the daughter caricatured to a certain degree the general attitude of the other family members in a curious and redundant behavior. Throughout the session she slouched in her chair, with her chin lolling on her chest. It was impossible to see if she was awake or asleep. When, every once in awhile, the therapist spoke to her, a tremor passed through her body as if she had heard an alarm bell, and she jerked up her head, with a leering grin on her face.

b) *The angry family:* This type of family appears to be irritated to the point of hostility. The members present a unified front, drawn up in ranks, and express in analogical language, especially in body language, the complete exclusion and rejection of the therapist. We have an eloquent example of such behavior in the first session of a family presenting an anorexic patient.

This family, of a low educational level, but at the same time financially well-off, came from the countryside, where their village doctor had insisted upon their entering into family therapy at our center. The family had agreed to do so out of respect for the doctor, towards whom they felt a long-standing sense of obligation. On our videotape of the session, it is amusing to observe the following sequence:

The family is sitting in a line facing the therapist (Selvini). As she speaks to them, the therapist leans slightly forward. She fails to solicit a positive response from them. The family lineup draws closer together. The therapist hitches her chair a bit closer, leans towards them, puts more expression in her face and more empathy in her voice. The family moves back and closer together, the expression on their faces becomes ston-

ier and more impenetrable. The observing members of the team, moved by compassion for the obvious frustration of their colleague, repeatedly call her out of the session to give some advice or other, but even when following these suggestions, she is unable to make a dent in the armor of the family. Within the next few sessions, the index patient lost weight alarmingly and her mother consulted two famous local magicians whose magic prescriptions she followed diligently. (They advised her that if her daughter's condition was caused by envy, she would find wood chips in the feather pillows. She opened all the pillows in the house and found the indicated wood chips in all the pillows but her own.) In the fifth session, the therapist declared her own impotence and interrupted the family therapy. In that moment, she saw the family members smile for the very first time.

c) *The complaining family:* This family complains about the discomfort it suffers in coming to the session, the length and cost of the trip, the inconvenience of the appointment time or day, the expense of the therapy, the lack of progress on the part of the index patient. Characteristically, this type of family does not follow prescriptions. It is in a hurry to finish therapy, to free itself of these pests (the therapists) and return to the referring person to declare that this experiment has been a failure.

What to do

In order to fully understand the problem of the referring person and to place it in its proper perspective, the family therapist must obtain adequate information concerning him. If the referring person has made contact by phone, or has come in person to present his case, we try to take into account any information or behavior which bears upon his relationship with the family.

In our experience this occurs only in a minority of cases. More often, it is a member of the family who contacts us and either volunteers the name of the person who has sent him or responds in answer to our questions concerning the referral service. At times the situation is immediately clear if the family member says, "Dr. so-and-so sent us, and he's been treating our daughter, (son, etc.) for years, and he told us he won't see us anymore if we don't come to see you for family therapy. . . ." Here it is obvious that the therapy can not begin without placing this information in a position of prime importance. In most cases, the referring person who sends the family to therapy with this type of ultimatum rarely places himself in personal contact with the Center, thus leaving it up to the therapists whether or not they should contact him.

We shall now describe what we do in these different cases.

1) *The suspected referring person is invited to attend a session with the family.* We are not speaking of the case of a family therapist who has turned to our Center for assistance. In this case, we always make an appointment for a consultation session in which the therapist is also present so that he may eventually continue the therapy on his own. Rather, we are dealing here with the case of a referring person belonging to the categories previously described, who has ordered the family to come to our center.

The first session with the family is dedicated to gathering information concerning the relationship the various members of the family have with the referring person and the reasons for which he has sent the family to our center. If it appears that the relationship has existed over a significant period of time and/or that it is an intense relationship, we can hypothesize that the referring person has become a homeostatic member of the family. At the end of this session, we state that we can continue the therapy only if the referring person is willing to attend personally in order to help us, given his profound knowledge and understanding of the family. We decline any suggestion made by the family to substitute for the physical presence of the referring person

with records, charts, or letters from his office. We insist that he come, given his understanding and concern.

In the next session, which is attended by the family and the referring person, we work prevalently with the latter, turning to him as a colleague who has been invited in order to supply essential information. By using this approach, we are able to see to what extent he has become a member of the family and to what point he has become exasperated with the total lack of change on the part of the family in spite of all his efforts and advice. At the conclusion of the session, far from criticizing him, we positively connote the work he has done with the family, and congratulate his failure. Here it is essential to avoid any sarcasm or irony, but rather to express our understanding of the feeling of frustration he must experience. During the session we have been careful to gather data which can be presented at this moment as reason for strict prevention of any change in the family system, stressing the dangers such change would present.

At this point, whether we decide to delay the next session for an appreciable period of time so that everyone involved can reflect upon the dangers presented by family therapy, or whether we accept the family in therapy by making a definite appointment for the next session, *we no longer make the mistake of advising or prescribing the interruption of the relationship between the family and the referring person.* In dealing with this fundamental point, we are careful to use the "prescription of the symptom", advising, even insisting upon the continuation of that friendship which has revealed itself as being so comforting and necessary for the cohesion and stability of the family. In this way, the position of the referring person as a member of the family group is implicitely pointed out.

The termination of the game between the referring person and the family, and thus the solution of the problem, should be the result of a session which has been properly handled. Then, and only then, can the therapists begin their work of treating the family.

2) *The suspected referring person is not asked to participate in the session.* In the first meeting with the family, we inquire closely into the family's relationship with the referring person. We are careful to avoid any tone of judgement or disapproval. If anything, we adopt an attitude of acceptance and good-naturedness. We ask in detail about the length of the relationship, the frequency of meetings and telephone calls, eventual gifts given on the holidays or on particular occasions. Above all, we seek information with which we can construct a graduated scale indicating the position of each family member in the relationship with the referring person, beginning with the member who has the strongest bond and working down to the member who has the weakest. (This inquiry is not always carried out at the beginning of a therapy. At times we are compelled to make this detailed examination in a more advanced phase of the therapy, when we first begin to observe behavior in the family such as we have already described earlier in this paper. In such cases, we discover that the family has minimized or held back significant information concerning its relationship with the referring person.) Once this has been accomplished, and, basing tactics upon the information obtained, we choose not to invite the referring person to attend the next session, but to make instead an intervention which includes him.

For example, this is a case that dealt with a family of three: mother, father, and a fifteen year old daughter, Christina. The mother had called the center for a meeting because of Christina, who, from the age of two years, after an attack of meningitis, had been in treatment with a well-known children's neurologist, Dr. Maria Finzi (a fictitious name). The mother explained that they had been sent by Dr. Finzi because at this time Christina was going through a difficult period: she was rebellious, made scenes continuously, and refused to take the pills presecribed. However, Christina was doing well in

school, and, in our opinion at the time, seemed to show no particular signs of being gravely disturbed.

In our discussion preceeding the first session, we decided that the first problem to examine was that concerning the neurologist who had been treating Christina for the past thirteen years and who, it appeared, had sent the family to our center because Christina refused to take the medication she had prescribed (an anti-epileptic).

In response to our questions concerning the family's relationship with the neurologist, we learned that the mother maintained an intimate friendship with her, with frequent visits, chats, and presents. The neurologist, besides controlling the EEG's of Christina and prescribing sedatives for her, also concerned herself with the girl's education, discussing it frequently with the mother and less frequently with the father (who, during the session, showed a marked disagreement with his wife on several points, especially those concerning the way to deal with Christina).

When we tried to clarify the motive for which the neurologist had referred the family to family therapy, we encountered a powerful resistance which indicated that here lay some vital issue. By insisting, we were able to learn that approximately six months before, the family, which had been paying the neurologist rather high fees for years, had by accident discovered that they had the right to free medical assistance for Christina at a regional neurological clinic. It was the father who was interested in bringing the girl to the clinic for examination and later returned for the results of these examinations. He had come home full of enthusiasm, having had a "marvelous" discussion with the specialist who had examined Christina. The results had been normal, and all medication had been suspended.

The mother, not at all convinced, had immediately made an appointment with Dr. Finzi. The moment they entered the office, Christina had declared petulantly that she had been examined by another doctor who had found her normal and who had said she should not take anymore medicine. "From that moment," sighed the mother, "even though I tried to explain how it had happened, Dr. Finzi ignored me completely and only talked to the child. She told her to stop taking the medicine if she wanted to, but that after the summer holidays (it had been June) she wouldn't see us anymore unless we came to your center. She said that you would have to study our family in order to discover why Christina is so unbearable, and then tell us what to do. I'm waiting for you to do that so that I can call Dr. Finzi."

Until this point, Christina had maintained an air of complete disinterest in everything that was being said. She kept glancing at her watch, and would answer in monosyllables or with the irritating phrase, "I don't know." whenever she was asked a question.

During the discussion of the team before the conclusion of the session, we decided unanimously to exclude any offer of treatment. The family as a whole was not at all interested in treatment, it had been the mother who had dragged them to the Center in order to obtain, *expressis verbis*, an appointment with the neurologist. As for the neurologist, it seemed evident that she had sent the family to our Center because she felt powerless and professionally disqualified as well as entangled in the competition and internal conflicts of the family. We finally agreed upon a paradoxical conclusion that had as its target the relationship of the mother with the neurologist. Here follows our conclusion of the session:

> *Ther.:* Our team is in complete agreement in excluding family therapy for Christina, because Christina is not sick. She does everything she does for a reason, even if she isn't aware of it. She is trying to maintain the relationship between her mother and Dr. Finzi, and she's trying to keep it in the right balance. Christina has known for years that her father isn't enough for her mother, that her mother needs someone she can confide in,

depend on, and she knows that she found all that in Dr. Finzi. But then Christina became afraid that the friendship between her mother and Dr. Finzi was getting too close, and that her father was beginning to feel left out. So Christina got naughty with Dr. Finzi, who got mad enough to send you all here to us. But, when you arrived here today, Christina began to worry again. If you really started family therapy, there was the danger that her mother would loose her dear Dr. Finzi. That's why Christina didn't cooperate today, why she was always looking at her watch, why she never answered our questions—to discourage us from taking you into therapy! (Turning towards Christina) In fact, Christina, we're not going to do family therapy with you. But you have to keep on doing what you've been doing until now, even if you get fed-up, even if you decide you don't want to anymore! Keep on behaving in exactly the same way so that your mother can keep her friendship with Dr. Finzi, but with the right balance! Not too little, or your mother will suffer and feel alone, and not too much, or your father will feel left out.

In other cases where the family relationships appeared seriously dysfunctional, as in families presenting members designated as schizophrenic, we have dealt with the problem of the referring person through systemic interventions which, while exposing the ongoing family game by connoting it positively, at the same time included, in an elusive and implicit manner, the referring person also, paradoxically encouraging and prescribing the continuation of the relationship.

Conclusions

The systemic model furnishes the therapist with the adequate means of defining and resolving the problem of the referring person. The systemic model, being of a superior logical level in respect to the linear-causal model, allows the therapist to place and to maintain himself in a meta-level in respect to family and referring person. Moreover, it seems quite important, even if only secondary, that the systemic model permits valid solutions without creating friction with the referring person, especially since the professional situation is already touchy.

Obviously a correct methodology would have required the consulting of all the files and records concerning the families treated at our center in the ten years of its existence. Unfortunately this proved to be impossible, since for many years we had underevaluated this aspect of family therapy, and therefore the necessary information was totally or in part missing. From now on we shall systematically collect data concerning the referring person.

All the same, we felt it useful to report these observations because in themselves they are indicative of the seriousness of this problem.

REFERENCES

Selvini-Palazzoli, M., Boscolo. L., Cecchin, G.F., Prata, G. *Paradox and counterparadox: A new model in the therapy of the family in schizophrenic transaction.* New York: J. Aronson, 1978.

Sonne. J.C., Speck, R.V., & Jungreis, K.E. The absent member maneuver as a family resistance. In A. Friedman, et al. (Eds.), *Psychotherapy of the Whole Family.* New York: Springer, 1965.

Wynne, L.C. & Thaler-Singer, M. Thought disorders and the family relations of schizophrenics. *Archives of General Psychiatry,* 1963, *9*, 191–206; 1965, *12*, 187–212.

NOTES

[1] It is indispensable to specify that the discussion of the problem presented in this paper is based upon the experiences of an autonomous and private center. Family therapy carried out in the ambience of an institutional context will obviously meet different problems.