Modality and representations of the client's referral as organizers of the request for help to the consultant psychotherapist

by Emilio Masina[1]

Introduction

In this article I want to underline the importance of exploring the area of the client's referral to the consultant psychotherapist in the setting-up phase of the intervention. In this area, in fact, one can identify fantasies and representations that organize the client's request for help and that, if they are highlighted and decodified by the consultant, facilitate the task of analysing the demand. I am referring to a theory of contextualistic, rather than individualistic technique. As it has already been underlined in this review, this entails considering not only the intrapsychic dimension presented by the client but also the intersubjective aspect To be more precise, it means considering the intrapsychic dimension that is not autonomous but part of a process that is organized in a domain that includes, but transcends, the individual (Salvatore, 2006).

In my training I have learnt to adopt, in the first colloquies with the client, a silent receptive attitude, waiting until the "unconscious speaks"; that is, relying on the property that is, as it were, self-organizing, by which the client structures and transmits his discourse in the here and now of the relationship with me. I try to understand the sense of what the client says and how he says it and I depend greatly on listening and exploring my countertransference. However, while this approach has often enabled me not to saturate the meeting with meanings and not to confuse the field of observation with comments that are too "cognitive", active and intrusive, perhaps oriented by defences against the anxiety aroused in me by the client, the results obtained are not always satisfactory. At times there seems to be a gap between the depth of observation of the client's inner world and my countertransference resonances and the difficulty of agreeing with the client on some critical points highlighted in his discourse and on the aims of a possible treatment.

Taking part in group supervision and listening to the accounts of others has made me notice that my difficulties are shared by others. The canonical four or five introductory colloquies in other words, can result in the proposal to do psychotherapy – often a big commitment for the client in terms both of the fee and the time to be spent, which may clash with other activities during the week ─ which does not take sufficiently into account the client's motivations, his desire to understand more and better what the outcome will be; in short, his demand. The consulting psychotherapist may be too hasty in pre-defining and orienting the client's demand towards psychotherapy, thinking mainly in terms of indications and counterindications of the treatment In such cases, the demand remains in some respects unexplored, the psychotherapist's proposal risks being of the "take it or leave it" type and it is often followed by a hurried and strongly emotional response from the client, who either accepts the contract or abandons the relationship and the problems it has evoked. I have often been struck by comments made by various acquaintances who have accepted the contract: "The psychotherapist put me up against a wall when he said that if I didn't accept his proposal there was nothing to be done"; "I felt as if he was leaving me no way out", etc. But also from colleagues who advised a sort of trick to motivate the patients: "You can propose a weekly therapy instead of a psychoanalytical therapy but making it clear that it will be less thorough and valid, a second class therapy".

In considering these critical points, I thought it would be useful to identify some indicators of how the relationship between the consulting psychotherapist and the client is gradually organized and acquires meaning. These indicators can facilitate the consultant's orientation towards the client rather than towards the achievement of self-referential goals. And I started thinking about the area of the referral, both when it is done by health professionals (doctors, psychiatrists, psychologists, etc.) and when it is done by family members or referents (teachers, sports trainers, priests, etc).

As far as I am concerned, the moment when a client is referred to me is always emotionally relevant. This is not only because I am involved with an unknown person who arouses interest,

[1] Specialist in Clinical Psychology, contract teacher of Workshop on adolescent unease, faculty of Psychology 1 at "La Sapienza" University of Rome psychoanalyst AIPsi and IPA.

curiosity, desires, fears: in short, a certain amount of trepidation (what will this person be like? How will he use me? Will I be able to make sense of his problems?). But also because, along with the client, I meet his relational context, including the referrer. A certain amount of satisfaction at the trust that the latter seems to place in my work may accompany the desire to live up to his expectations; or there may be irritation at the way the client was referred to me and at the theories, explicit or implicit, on the significance of the intervention and on its final outcome that I am expected to accept. Over time, I have realised that if these emotions are recognised and elaborated by me, they facilitate the work of understanding the client's problems and returning them to him; if this does not happen, they can result in acting out that complicates the management of the intervention.
In my experience it is unusual for the referral by health professionals to contain guidelines or formalized directions. This is perhaps because it is still an open question whether psychological interventions and various forms of psychotherapy are to be indicated differently according to the type of client and the type of disorder. Sometimes the referral goes no further than a practical communication in which the availability of the consulting psychotherapist is explored, he is asked when and where he prefers to be called, he is given the surname of the person he would have to treat, as well as a few details on the type of problem involved. In this case, the criteria for the referral seem to respond above all to concrete needs (placing the client, creating and maintaining a network of contacts that favours the cross-referral, etc.). Also when the referral is made in the "public" domain it seems to focus mainly on the organizational aspects (availability of specialists, waiting lists, etc). However, the question of the criteria used for the referral is only seemingly solved when a diagnosis is sent to the consulting psychotherapist. The latter, in fact, responds to categories that describe, but do not explain, the client's problems. Moreover, the diagnosis is generally modelled on an "individualistic" rationale that proposes "essential" items ("the individual", "the couple", "the family") rather than "situational", that is, regarding the relationship between the individual and his context.
In other cases, it is easier to distinguish a manifest and a latent content to decodify in the referrer's communication. This is so for example when the psychologist refers a boy to a colleague that he knows has a son the same age and will therefore be able to understand the situation better.
In all cases, however, with a deeper appraisal it can be seen that the referral is supported by hypotheses on the nature of the psychological problems to be treated, on the type of intervention to carry out, on the technical resources needed and on the outcome to achieve. These hypotheses are at times peculiar to the referrer, other times shared by the latter and the client. Suffice it to think of the frequent dialogue in which the interlocutors wonder whether it is better to find a male or female psychotherapist, which reveals naïve ideas of matching-up since it treats the psychotherapist exclusively as a concrete object, ignoring the symbolic meaning in transference. Even when the referral is made by family-members it allows one to see and highlight a "fine line" of expectations weaving a fabric of the commissioning-party/client/consultant triangle. The family-members, in fact, unconsciously and collusively allocate to themselves the role of commissioning-party and client of the intervention, using defence mechanisms of projection and dislocation of the psychic disorder in the other person, and/or of the motivation to deal with it. Here then one must perceive and patiently unravel a real web of transference towards the consulting psychotherapist and the clinical intervention.
The referral, in other words, clearly shows that the demand addressed to the psychotherapist never comes from one single person, but involves several actors and factors and is not only the expression of difficulty and suffering (or of positive resources finally coming into play) but is above all a manifestation of desire (Michelot, 2002). The psychological intervention therefore intrinsically has a social function and the work undertaken can be described as a co-elaboration (Michelot, op. cit.). The referral concerns one of the aspects that the professional, according to Dubost (in Michelot, op. cit.) has to examine to construct the client's request; it is an aspect that, to be methodologically correct, the author recalls with some questions: "What factors pushed the making of the demand? What situation preceded it? What is the context from which it emerged?".

These questions, along with others proposed by the author[2], invite us to consider the demand as a moment in the history of the person or of the group and to take this history into account.
However, issues concerning the referral are rather neglected in the literature. Clinical case reports usually begin by taking for granted the meaning of the client's demand and the choice of the intervention strategy, and this prevents us from reflecting on the setting-up stage of the intervention to understand if and when the demand was analysed in the relational context that gives it meaning or was simply acted out.
Freud was the first to point out the importance of the referral and to indicate it as a possible source of problems, concluding that some forms of incompetent referral were counter-indications for the client's psychotherapy. Freud links the questions about the referral and the context in which it was decided to undertake psychoanalysis to the problem of motivation and transference. The Author (1904) writes that psychoanalytical psychotherapy is not applicable to people who do not feel pushed into therapy by their suffering but who undertake it only on the higher orders of their family-members; and also that the psychoanalytical method is often confused with hypnotic suggestion treatment. I point this out because relatively often patients are referred to me even by colleagues whose trust I do not usually enjoy, indifferent patients, naturally, with the request to hypnotize them (Freud, op. cit.). In 1913, among other counterindications, Freud signals that long preliminary conversations before the beginning of the analytical treatment, a previous therapy of another kind, as well as a pre-existing acquaintance between the doctor and the patient, which makes the patient present himself to the doctor with an attitude of already defined transference, preventing the doctor from observing the growth of the transference from the very beginning; but also the request for a referral, concealing strong resistance.
These passages seem to indicate a specific attention to the meeting between human beings, rather than to the subject-object of knowledge, to the transference-countertransference dynamic, and more generally, to the context of the clinical intervention, which exerts its influence on both the client and the therapist. The context that must be considered is not only that of the inner context of the client (the psychic context of the pathogenic idea that psychotherapy aims to eliminate, as Freud wrote, again in 1904) and nor is it the context that enables the theory to be proven, but it is also and simultaneously, the context in which theory can be "constructed" and modified.
However, the idea that the client should arrive in front of the consulting psychotherapist without an attitude of definite transference seems today a naive expectation[3] This is so also because we can differentiate between different kinds of transference. David and Jill Scharff (1991) for instance, refer on the theoretical plane to the Winnicottian theme of the difference between environment mother and the object mother to outline a difference between what they call contextual transference and focalized transference. C*ontextual transference* is supposedly tied to the patient's responsiveness to the therapeutic setting, that is, to the attitudes concerning the framework of the treatment: unconscious resistance in general, specific conscious feelings and behaviours towards the therapist as an object offering a supportive situation. On the other hand, *focused trasference* supposedly concerns feelings the patient transfers to the therapist as the object of an intimate relationship. And Carli (1995, 1997, 1998), points out that in the psychotherapy intervention one can identify, along with historical or personal transference, which concerns the reactualization in the relationship with the psychotherapist, of relationships

[2] What activities (training, diagnosis…) are requested and what kind of efficacy is expected? Who to? What criteria led to the choice of a particular psychotherapist?
[3] With his feet firmly on the ground is Saraval (1988), a psychoanalyst of the Italian Psychoanalytical Society: "If the potential patient phones directly it is a good start. It is less positive if the appointment is made by the family doctor or by a family member, because this indicates that the patient is being 'sent to do psychoanalysis' In this case there will be a strong likelihood of seeing right in the first meeting that the patient is not motivated enough for the analysis … I could say 'well-motivated patient, analysis half over'. If a patient turned up saying: 'I understand that my suffering is caused by my psychological difficulties. I have tried hard to work out what the origin could be but I get to a certain point and can go no further, so I think I need analysis to help to understand myself fully and to change myself. I know it's expensive, long and difficult, but I'm ready to make the necessary sacrifices', now, if a patient said these things, it would be the ideal patient".

established with archaic inner objects, also an “unvarying” transference. The latter concerns the reproduction of the dynamic of the doctor-patient relationship, within which Carli identifies an “organizational” component based on contractuality and regulated by well-known, shared social norms, and an “institutional” component based on the symbolic-affective elaboration of the positions on the one hand of caring, and on the other of being cared for by another. In the relationship between psychotherapist and client, on top of the unvarying component (despite the variability of the institutional dynamics reproduced) the personal component of transference is superimposed, or added; this happens in a very complex relationship: “One can think that the patient’s affective history, his inner world and the archaic objects that populate it, are projected onto the psychotherapist insofar as he represents the one who will free him from evil, and who can give him his good. Therefore it is the therapeutic function that triggers the transference process, and it is on this function that the personal transformations of the single patients will be built, based on their history” (Carli, op. cit.).
We can hypothesize that the various specialists consulted over time by the client are mentally positioned by him along an associative chain in which unvarying transference constitutes, as it were, the skeleton, and the personal transference the fantasies and the affects that are supported by it.
I will also recall that Glover (1954) pointed out the “spontaneous” or “fluctuating” transferences that are present right from the beginning of the relationship and reflect an individual’s habitual object relations while the English Tavistock authors (Boston & Daws, 1981; Box, Copley, Magagna & Moustaky, 1985; Copley & Forryan, 1989) have talked about pre-transference, or precocious transferences. The latter are already established at the time of the first consultation or even before the meeting, when the phone call for the appointment, or even the mere disposition to wait, trigger fantasies about the consultation and its outcomes in both the interlocutors. These authors share the assumption that rather than exploring the intrapsychic determining factors of the subject presenting a psychological disorder, the consultation should explore all the interpersonal values that, through projective identification, construct a defensive system that prevents the emotions from circulating. Pre-transference is considered different from infantile transference on the therapist, which is triggered in psychotherapy, is elaborated slowly in the course of time and favours greater regression, because it is explored and interpreted in the *here and now*, and has a greater appeal to the more adult parts of the personality. Moreover, the fantasies expressed in the early interviews, unlike transference proper, do not always have a dual nature that can be elaborated in these terms, but can represent complex relationships between one, some or all the members of a family, the psychologist and/or the institution in which the latter works.
In this approach, the feelings experienced by the client in the consulting room towards the consulting psychotherapist, are used as concrete examples of the nature of the client’s relations with significant figures present in his context and enable him to explore, with the therapist, his own attitudes towards others both in his inner and his outer world.
We could compare the concept of pre-transference to what Grasso and Bianco (2003) call the prevailing relational fantasy, which is acted out by the individual at the time he contacts the psychotherapist: “This fantasy contains not only the characteristic behavioral elements with which that person tends to manipulate and use others for his own “pathological” ends but also the more or less realistic expectations that have been triggered by the decision to ask an “expert” and the institution he is part of, for a psychological intervention” (Grasso & Bianco op. cit. p.32). These expectations are not produced in a “social vacuum”, nor are they activated only by childhood reminiscences[4], but they are constantly in interaction with the various relational roles present in the current context and with the psychotherapist’s social mandate that is incorporated, as it were, in the transference.
Also the French psychiatrist Gilliéron (1994) is interested in what he defines the forms of precocious relationship of the client with the psychotherapist, and in the effects of the constitution

[4] Freud (1901, 1912) subdivided transference into real “reprints”, whose contents remains unchanged compared to the past, even though the object at which they are directed changes, and “copies”, which can be “edited” so as to have a particular connection with the present relationship. And he pointed out that it was precisely in reliving old emotions in a new relationship that there was the therapeutic possibility of change and growth.

of the setting on the psychic functioning of the participants. The author's theory identifies as crucial the function of the supporting object that the client asks for from the psychotherapist in order to restore his previous equilibrium, and proposes assuming a modality of consultation centred on the exploration of the request to the therapist and of the related expectations, which would correspond to the changes sought by the client, consciously and unconsciously. According to the author, the fact that the client is referred by any "third party" whatever signals, at first sight, a problem on the interpersonal level, between the subject and his relational environment: referring a patient to a specific doctor implies a double movement: the recognition of one's own impotence in dealing with the problem and the recognition of the other's competence. It is firstly the attitude of the person referring the patient that must be studied, and only later the content of the message. This attitude will provide important information about the reactions caused by the patient (countertransference). All this is because the psychotherapist's emotions will already be strongly activated by whoever intervened previously, before the patient had the slightest chance to act (Gilliéron, op. cit.).
Analysing the modality of the referral and of one's own countertransference sometimes enables the consulting psychotherapist to hypothesize that the referrer adopted a two-stage intervention: firstly the case acceptance in collusion with the client's proposal, and then when the relationship failed, a referral to other specialists. The latter action implies the inability to face the failure of collusion with the client and represents the attempt to relieve the emotional pressure of the relationship by asking the colleague to take responsibility for some aspects of the intervention, already defined by the referrer and foreseen in their final outcome. The referral, in other words, can conceal the referrer's desire to control the intervention at a distance It could also be said that by implementing mechanisms of delegation, idealization and control, the referrer "does" to the colleague what was "done" to him by the client. It is probably no accident that among those involved in the field, there is the saying that one should beware of "bad" referrals!
Naturally, it is above all the client's experiences and representations of the referral and the referrer that make it possible to understand the "client system", in a context, in an organization. The modalities of referral, the representations of it that are given by the client and the consequent representations that are evoked in the consulting psychotherapist can be considered organizers of the client's demand.
A particularly interesting case is that of clients who come to the consultation with the psychotherapist after having been treated by other health professionals in the distant or recent past. It is not unusual for these demands and the interventions arising from them to have produced a growth of collusive acting out that need to be patiently analysed, so as to call the clients to take on the role of the one commissioning the psychological intervention, to facilitate their coming to awareness and the growth of their mental resources. It is in fact the identification of the expectations and affective symbolizations underlying the demand for help, and their return to the client, that constitutes the specificity of the intervention of analysis of the demand (Carli, 1987; Carli & Paniccia, 2003).
In these cases, the intervention is particularly complex, for various reasons: the clients, who have split up and scattered their economic and mental resources in different directions, are disappointed and impatient; in other words, they express distrust and concern towards the clinical psychologist[5], demanding an "everything, at once" answer to free them from anxiety. Otherwise, they demand a certain kind of performance rather than another, foreseeing the final outcome of the intervention and trying to control, provoke and oblige the psychologist to make it possible.
Secondly, relationships with the previous specialists and/or the various institutions of treatment, and/or interactions with other interlocutors, such as family-members, have often produced not a weakening of defences but a strengthening: psychological theories, diagnosis, hypotheses of treatment, bits of therapy have sustained and fed the collusive circuit, helping to build a relationship of the client with the so-called expert and/or institution in a "taste and run" style. The interventions of the "expert", in other words, have been used like a sort of supermarket drug, in the illusion of blocking the symptoms and curing the deficit of the moment. They therefore had the effect of a sort of training in reverse: acting out rather than conceiving of the emotions, depending acritically on the specialist, satisfying one's desires for belonging and contact, rather than using it to develop one's competence in coping with the psychological problems present. When clients are

[5] See the neoemotional tree proposed by Carli & Paniccia (2003, 2005).

asked what they understand of what they have been told and from what they have done with the "experts" consulted, the answer is often "Very little!"; or "Nothing!"; or simply unsupported statements of principle[6]. At times, the clients also repeat a diagnosis that has served to give their anxieties a name, as wrote Balint (1957), but not to analyse them and understand their meaning.
The analysis of the demand allows one to highlight, in all these cases, a high propensity on the part of the client to "blindly" follow some specific fantasies about the meaning of his own problems and/or about the figures in his relational world, as well as about the purposes of the relationship with the consulting psychotherapist, rather than using the latter to think them out together. The return to the psychological consultation, in these cases, does not have the sense of renewing a commission, but mainly that of delegating another specialist to solve the problems. The latter can find himself in the difficult countertransference position of "financing" the intervention project himself, responding both to the client's expectations and to those of the referrer, implicitly or explicitly interrelated.
In conclusion, the representations that both the client and the consulting psychotherapist make of the referral and of what inspires it and precedes it – the social mandate to modify maladjusted behaviours, a diagnosis, the meaning attributed to the psychological malaise, the indications for a specific treatment, the theories about matching that subject with that particular psychotherapist – are a powerful organizer of the representations of the self, of the other and of the relationship between the two. They can therefore be explored in the work of consulting to trace and understand the *failures of collusion* in the relationship between the client and his referrer, which is an indicator of the crisis of the relationship between the client and the other significant figures in his context of life, as well as the fact that in the demand for help addressed to the consulting psychotherapist, the affective symbolizations related to the failed collusive situation are reproposed. This means that the referral is one of the aspects that go into constructing a specific relationship between the client and the consulting psychotherapist and that helps to determine the treatability of the case (Masina, 2000).
The characteristics of the referral, that is, everything that is said and done by the referrer, as well as the client's experiences accompanied by those of the consulting psychotherapist, can represent one of those critical events that, as has been underlined many times (Carli, 1987; Carli & Paniccia, 2003; 2005), favours the reconstruction of the plot of the collusive relationship. Through the analysis of the client's fantasies about the meaning of the relationship with his referrer, it can be understood whether on the part of the client the prevailing interest is in correcting a deficit, or on the other hand whether the relationship will be used above all to promote growth.
The first aim of the intervention is therefore to introduce and develop in the relationship with the client reflection about the sense of the demand addressed to the consulting psychotherapist and about the outcome of the interventions carried out. In other words, a "third party" must be allowed into the consultation relationship, opening to the dimension of otherness inside and outside the client.

A case[7]

The mother of a 16-year-old boy asks for a consultation with Dr. L., explaining that her son does not want to study: last year he failed the year at the state school and this year was expelled from a private school for beating up a classmate. The boy also smokes a lot of "spliffs" and is a small-time pusher, coming home at dawn and participating in fights in the town square. The woman confesses that she no longer knows what to do. She moved him to the private school because in the public school her son had found two mad teachers who had been too strict with him (she explains that they had also been subject to a Ministerial inspection) but after the beating-up, the headmaster of the new school had expelled him without even trying to understand the reasons for his behaviour. The only positive factors, according to the woman, are that the boy does not hide things but tells

[6] For instance, a client answers: "That I've never known my husband"; another: "That I treated my son too tolerantly", etc.
[7] The case was followed by me in supervision. Many thanks to Dr. Lorenzo Limiti for allowing me to publish it.

her everything – for example, he complained about going to a new private school, an "exam factory" where students catch up the school years lost, which he called a school for idiots.
The woman explains that she and her husband have been treated as a couple by a psychologist (Dr. A) who, after finding that the boy was not willing to take part in a meeting with him, firstly suggested they should be very flexible with their son, and later when this strategy was unsuccessful, that they should become increasingly strict. Others (the woman's sister-in-law, and a psychotherapist friend) had also told her she had to be strict and control her son: for example by taking away his moped when he behaved badly. It is above all the father who should deal with setting rules. The woman explains that they, the parents, have tried: but the boy simply takes the moped anyway, and when he comes home, her husband gets very angry: she is afraid the two of them will start fighting and get hurt and she has to intervene to separate them. But this irritates her husband. Consequently, they don't know how to behave. The boy seems like an angel until the mother makes some slightly critical remark about his time-wasting, dangerous behaviour, or refuses to give him the money he asks for. Then he gets furious: he insults her, getting close to physical violence, or he disappears. Later he comes back, promises again to be good and makes further requests for attention and money. The father, on the other hand, is usually out at work all day.
The increase in the boy's troublemaking and violent behaviour towards his parents and in the use of substances led Dr. A. to advise referring the boy to a centre for drug-addicts: the boy went once but refused to go again. After these failed attempts, the woman's husband, already sceptical about psychology, withdrew and the psychological work on the couple turned into a psychoanalytical psychotherapy for the woman with the same Dr. A. However, the woman does not seem satisfied with this intervention either: the results will be in the long-term, while what she needs is help "now".
Dr. A. sent the woman to Dr. L with the aim of organizing with him a request for Social Services and the Minors Court to issue a compulsory therapy for the boy; this treatment should be carried out in a centre for teenagers, known and officially recognised by the Court, where Dr. L works. In this way it will be certain that the boy is being treated by competent people.
The woman seems very pressing in her requests for concrete assistance and for "prescriptions" to help manage her son. She says she has two other older children. At their brother's age they too smoked spliffs but then they grew up to be "fantastic": they graduated with full marks, excel at sport, and one of them has recently won a scholarship to a prestigious university in Paris. Soon the three children will be leaving for a holiday together, in which she has great hopes. But first she, her husband and the son will go to Paris to visit a college famous for its good educational results, where the boy could be accepted. She hopes in this way to get the boy out of the bad environment he frequents in the town and she hopes that his brother who lives in Paris will be able to spend time with him, at least on Saturdays and Sundays. After a lot of resistance, the son seems willing to go.
During the meetings, Dr. L's attempts to make some comments on the situation that has developed are repeatedly interrupted by the woman who vehemently rejects his hypotheses, asking for a rapid intervention and not just words, and tells him that Dr. A said to tell him that the case is already being followed; so there is no time to lose and the Court intervention must be got underway. Dr. L, in countertransference, feels controlled by the Dr. A-woman couple which seems to be giving him a rigid mandate and a script to follow. Dr. L's irritation is increased by the fact that the referrer, Dr. A., who he respects, did not call him to talk about the situation but sent him a message through the client.

Commentary

Dr. A's referral to Dr. L. represents a critical event that reveals the failure of the collusion between Dr. A and his clients. The demand for consultation, in fact, firstly made Dr. A. give pedagogical advice on the management of their son; then, to propose psychoanalytical psychotherapy for the woman and lastly to prescribe a therapy for the boy at a centre for drug addicts. It seems that Dr. A. and the clients have brought into play a series of ideal expectations which later were not fulfilled. The first expectation was that it was possible to overcome the difficulties the parental couple had in constructing a more suitable front to deal with the teenage malaise through a "strong" intervention by Dr. A (prescription of pedagogical techniques and therapy for the boy); secondly, the

expectation of overcoming the father's demotivation and his giving up the consultation by giving an individual psychoanalytical treatment to help the woman to separate herself from her son. These strategies, in fact, were unsuccessful in preventing the boy's situation from worsening and the clients from becoming more dissatisfied. After her husband's withdrawal, the woman asked for a rapid intervention with more urgency and Dr A. prescribed the Court, compulsory therapy and the woman's visit to Dr. L. so that the latter would organize the intervention in detail.
In other words, Dr. A's "advice" seems linked to his difficulty with dealing with the ambivalence of the demand of the client, who after evoking a competent interlocutor, wants to show his unreliability, so as not to have to question her own role in the couple, in the family and in the psychological consultation itself.
In fact, while the woman asks Dr L. to proceed with the intervention arranged by her and Dr. A, she shows, through her doubts about the latter's interventions, that she has already eliminated him. Dr. L. seems to be only the last link in the woman's chain of interlocutors (the son's teachers, the headmaster, the sister-in-law and the psychologist friend, her husband) called on to play the role of the third party in the relationship between herself and her teenage son but immediately eliminated as unable to provide valid help. It is no surprise that soon after the new request for help, the woman breaks off her individual psychotherapy with Dr. A.
At the same time, the woman's son who is giving signs of being weighed down by great distress, is still expected by the woman to play the role of the imagined son who, by changing environment and interlocutor (the brother, a paternal substitute) will have an excellent development. We could say that also in this case the woman cuts out the extraneous part of the interlocutor that forces her to face the limits of her representation of herself, of others and of the relationship: that is, the part of the son intent on escaping from maternal control, expressed for instance in his comments that the private school is made for idiots.
The irritation of the clinical psychologist when faced with the client-referrer couple can be connected to the feeling of the boy and of the woman's husband but perhaps also that of Dr. A. – who takes pains to control the relationship between Dr. L and the woman, claiming a kind of priority in the intervention – that the woman is "double-dealing", each time using obliging interlocutors. On the one hand the woman seems, in fact, allied with him, promising him to listen and be devoted; on the other, she is always in search of a different relational object to help her to cope both with the boy's requests, which are more and more pressing and intolerable, and with the difficulty of negotiating new roles and new representations of herself with Dr. L.
We can hypothesize that the teenager's rejection of the psychological intervention is connected to the meaning that the parents have attributed to it. This was that of correcting a deficit compared to their expectations, rather than promoting a better Self-representation to help the boy pursue the development tasks typical of adolescence. The psychological intervention that is proposed to the son seems in fact to take the place of, rather than integrating, both the ability of the parents to collaborate in giving the boy back a clearer, completer picture of himself, and that of the teenager himself to understand the incongruity of a situation in which he is trying to grow up but at the same time to remain a child, overcoming Oedipus without playing the match with his father, "in the abstract", as it were. By adhering to the woman's request, Dr. L. would be configured as a kind of extension of the mother's control and would set the seal on the impossibility for the boy to free himself of her.
The possibility of returning to the woman the sense of her attempt to re-establish with Dr. L. the collusion that had previously failed with her husband, Dr. A, and her son, emphasising the defensive side, aimed at controlling the other and at denying its otherness, outside and inside herself, enabled Dr. L. firstly to re-engage the husband, and then to proceed to a meeting with the whole family in which to discuss the problems that had emerged in recent years.

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