The Art of Referral in a University Mental Health Center

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ABSTRACT. With the growth of managed care into university mental health settings, clinicians there often find themselves in unfamiliar role of ''gatekeeper,'' deciding who shall receive psychotherapy and referring those clients to an outside clinician for psychotherapy. However, the rates for client follow-through on these referrals are often low. Based on the experience of one clinician and his supervisees, the present discussion presents a framework for understanding the referral process with university students and for improving rates of follow-through. It is assumed that the psychodynamic forces, including transference and countertransference, operative during long-term therapy, are also at play during the referral process. When unanalyzed, many of these forces can interfere with follow-through. On the other hand, attention to these psychodynamics can increase the probability of follow-through by informing the referral process in relation to timing, interpretation, and the creation for the client of a transitional space from one clinician to the other. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com>]*

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Today, with much of psychotherapy controlled by managed care, many clinicians in university mental health settings find themselves in

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the position of ''gatekeeper,'' performing triage, deciding who should get what psychological treatment, if any, while the actual treatment is performed by an outside clinician (Lawe, Penick, Raskin, & Raymond, 1999). Two aspects of this process have been abundantly discussed in the literature. The first is how to assess whether psychotherapy is appropriate for a particular client (Garfield, 1994), and the second is how to select a modality (individual, group, family), orientation (e.g., psychodynamic, cognitive behavior therapy, psychopharmacology), and therapist to match a particular client (Shapiro & Shapiro, 1982). Yet, even when these questions are wisely resolved for a particular client, a referral is not successful if the client does not follow through on the recommendation. Although the conjoint activities of referral and follow-through thus play a critical role in the mental health care system, they are little discussed, researched, or taught, and consequently, little is known about what determines their success (Cheston, 1991; Matas et al., 1992).

In the approach described here, the referral process (RP) is itself conceptualized as a psychotherapeutic process, and the psychodynamics of the RP are assumed to be qualitatively identical to those operative in long-term psychotherapy. Most likely, many of the same forces creating the problem that brought the client in for help will assert themselves in the RP. For many clients there is a sense in which they must first overcome their neurosis in order to get treatment for it. The present discussion, based on the experience of one clinician and his supervisees, is a first attempt to articulate these psychodynamic forces contributing to the outcomes of the referral process. In particular, the focus will be on those interactions promoting positive outcomes in which: (1) the client follows through, i.e., begins therapy with the referred-to therapist, and (2) the chances for success in the referred-to therapy are enhanced.

SETTING

I am a part-time clinician in a mental health center based in a university health service serving students, faculty, staff, and dependents. Non-students can choose to pay premiums and join this health plan. Most treatment is short term, following a treatment model adopted by many university mental health centers (e.g., Quintana et al., 1991; Pinkerton & Rockwell, 1994; Backels & Meashey, 1997). Clients requiring long-term therapy are referred to private therapists or

out-patient clinics for treatment. The health plan pays for a portion of the fees for this outside treatment, and the client pays any balance.

I estimate that I have made over 200 such referrals. Of these, I estimate that nearly 85% of these referred clients have made contact with the referred-to clinician within one month after the referral. My data come from follow-up conversations with referred-to therapists and from insurance claims clients file to receive insurance payments. On the basis of informal discussions with colleagues as well as published data (e.g., Farid & Alapont, 1993), I believe that this is a relatively high percentage, especially with an age group found to have a higher incidence of failure to keep initial appointments with mental health professionals (Nicholson, 1994). Statistics compiled by my mental health center also show that the percentage of clients I refer is above the average for the center.

The present discussion is an attempt to record what I and my supervisees do in the hopes that some of what is described is relevant to the success of a referral. Because this is not a controlled study, it is not possible to know which, if any, of the factors described actually contribute to the rate of follow-through. Furthermore, the generality of my conclusions may be limited because my clinical population is not representative of the general student population in that it is selected from the student body of an elite institution with a heavy emphasis on science and engineering. Nevertheless, much of what is described may be helpful to others in understanding the process of referral.

TIMING

RP is not simply the act of recommending to clients that they seek treatment and providing them with the name of the referred-to therapist. Instead, the referral should be conceptualized as a process encompassing all the interactions occurring in the period between the client's first communication with the referring clinician and the client's first appearance in the office of the referred-to clinician. This RP usually consists of at least one office session but may consist of more and may also include telephone calls, e-mails, and other forms of communication among the referring clinician, the client, and the referred-to clinician. All the activities of the RP must be considered in trying to determine what makes a referral effective.

As in any important human interaction, both the client and the

clinician in the RP have many expectations, transferences, hopes, and apprehensions. Most of these are specific to the individual client, but many are shared by most people who enter a mental health center seeking help. The art of referral requires an appreciation of these emotions and cognitions, both those of the client as well as the referring therapist, so that they do not interfere but rather facilitate the referral. In this way, the RP can be seen as a psychotherapeutic encounter (see also Seager, 1994; Epstein, 1990).

During the RP one common set of feelings arises, consciously or unconsciously, when the client learns that the clinician conducting the initial interviews will not be the long-term therapist. This can create a negative transference toward both the referring clinician and the referred-to clinician. Often it has taken a good deal of courage and will power for the client to see a clinician in the first place, given the stigma associated with having a psychological problem and seeing a therapist. Further will power is required to tell a stranger details, often embarrassing and secret, about one's most intimate life. To learn that one's Herculean effort will have to be repeated, that one will have to tell the same story to yet another stranger can be a profound disappointment. Added to the disappointment is the shock of learning that a professional thinks the presenting problem is so ''serious'' that it cannot be resolved immediately but requires ''long-term'' work. This often confirms one's worst fear.

In addition to the dashing of hopes and expectations, there is often a sense of betrayal. Given the hopes and wishes that the client invests in the first clinician, it is not unusual for the referring clinician to be the target of an initial positive transference. These positive feelings can be dashed and replaced by feelings of abandonment when the client learns that this ''wonderful'' clinician is transferring responsibility to someone else. The client can easily feel abandoned. Similarly, the client may feel betrayed by the health plan. Presumably, the client has chosen this particular plan from among many, has paid premiums, has trusted health and well being to the plan and now, in time of need, is sent away (off campus) to someone not directly affiliated with the community, requiring travel and payment.

All these negative feelings, contemporary versions of earlier feelings of betrayal, abandonment, and disappointment, can interfere with the process of referral. They may cause the client to fail to follow through with the referral, to distrust the referrer, or to approach the

referred-to clinician with mistrust and suspicion. What can the referring clinician do to alleviate these feelings?

First and foremost, the referring clinician must be forthright about how the procedure works. As soon as it appears that a referral may be appropriate, the client should be told that not all problems can be alleviated in just a few sessions, and some require more time and regular meetings. The referring clinician can explain that although we at the mental health center do not provide this kind of treatment, we will find and help pay for an appropriate referral.

However, it is possible to say all this *too* soon. Saying this before the clinician fully understands the reason for the visit is premature. It can sound legalistic, distancing, and self protective, said for the benefit of the referring clinician and the health plan rather than for the client. Thus, like so much of clinical practice, there is an art to finding the right time to explain all this to the client: Not so soon that it sounds cold and not so late that it is unnecessarily disappointing to the client.

Besides being forthright about the procedure, the referring clinician can also respond to the client's feelings of disappointment and betrayal by making tentative interpretations of these feelings when they manifest themselves. Signs of resistance to following through or incipient disappointment can be understood in the emotional context of the RP. When the clinician brings these feelings to consciousness and empathizes with them, the client may be enabled to resolve the feelings and follow through on the referral. Equally important, such interpretations demonstrate to the client what happens in psychotherapy, how transference operates, and how interpretations can help.

For other clients, the referral can evoke a variety of feelings other than disappointment. For example, clients with a masochistic character may enter the initial session feeling that they deserve to suffer and should not impose on others, including mental health workers, with their ''frivolous'' complaints. Similarly, those with a harsh super-ego may feel that they should be able to overcome their mental suffering with greater will power or that emotional pain is not real pain. For such clients, the recommendation that they need intensive treatment rather than the one session they had hoped would cure them may elicit feelings of guilt and shame. On the other hand, the referral by a respected professional, with the implicit acknowledgment that the client deserves help, may come as a welcome relief. Because the clinician is neutral, the evaluation and recommendation can carry

great emotional weight, greater than that of supportive friends and family, who may have their own interest in seeing the client in treatment. In this context, the referring clinician may have a strong advantage over the treating therapist. Unlike the latter, the referring clinician gains no obvious benefit from the referral and, indeed, may be seen as working against self interest because the health plan incurs an additional expense for each client referred.

Here again, early interpretations can be helpful. Clients can come to see how the self defeating thoughts and behaviors that brought them into the mental health center in the first place are now interfering with their ability to find solutions. They may use these interpretations to overcome the guilt and shame they associate with asking for and receiving help. Not only do such interpretations demonstrate for the client what happens in psychotherapy, but they may also be recalled at a later time when the client is contemplating a premature termination of long-term therapy because of the same feelings.

Whatever the patient's reactions to a referral, be they disappointment, anger, guilt, or fear, the clinician's interpretations and empathic response increase the likelihood that the client will follow through. Furthermore, by demonstrating the therapeutic process and its usefulness, interpretations during the RP prepare the client for long-term therapy and increase the likelihood that it too will be successful. However, there is also a disadvantage to interpretations during the RP. Inevitably, effective interpretations will reinforce the client's favorable impression of the clinician and strengthen any positive transference. This, in turn, will make it more difficult for the client to leave the referring clinician. The client may feel not merely abandoned but *seduced* and abandoned.

Once again, good practice is an art. On the one hand too little interpretation may occasionally result in transference feelings sabotaging the follow-through, while, on the other hand, too much interpretation may strengthen a connection which must be severed if follow-through is to occur. One technique that may be useful in this context is to try to limit the RP to no more than two sessions. This seems to allow for some interpretation and at the same time limits the attachment.

Aiming at a two-session RP also mitigates the effects of some countertransferences that may arise. When one has offered several good interpretations that are well received by the client, it is easy to

slip into the narcissistic fantasy that one is the very best therapist for this client, and one can come to share the client's fantasy that the referral really is an abandonment. The referring therapist then readily finds reasons for extending the RP sessions although this is usually not in the client's best interest, as we have seen. A two-session RP helps guard against such countertransferential acting out.

Two sessions should also be seen as a minimum RP length. Often clients are taken by surprise by the recommendation for long term therapy. They need time to deliberate about such an important step, and they cannot do this when coping with the anxiety accompanying a first session. In addition, as they think about therapy, many questions will come to mind that were not considered during the initial session. Left unanswered, some of these questions may block follow-through. Leaving a week or two between sessions (assuming the situation is not urgent), allows time for the client to mull over the issues, consult with friends and relatives, and raise questions.

Another reason for a second session is that it affords an important second time sample for both client and clinician. Lives can change very rapidly, especially for young people. What seemed so critical at the first session may not seem so at the second. In addition, a second session also serves as a measure of motivation. Even clients who appear eager to follow through on a referral after the first session may not keep a second appointment (Reiher, Romans, Anderson, & Culha, 1992). A one-week interlude may be enough time for resistances to reassert themselves and to block follow-through. Perhaps this possibility argues for an immediate referral during the first session before motivation weakens, but I would argue that there is no reason to believe that the same resistances will not reappear immediately after a referral in the first session or even in the referred-to therapy and prematurely terminate it.

For all these reasons, I nearly always insist on a second session before making the final referral. I also urge clients to return for a second session even if they decide during the interim not to seek a referral. In that case, the purpose of the second session is to monitor the problem that brought the client to the mental health center in the first place and to discuss the client's thoughts and feelings leading to the decision to decline further treatment. In this discussion the clinician and client may come to an agreement that further psychotherapy now seems unwarranted. Alternately, the clinician may still feel that

long-term psychotherapy is indicated but that the client is not ready at this point to follow through. Under these circumstances, the clinician can help the client to understand the defenses contributing to the decision. These interpretations can be offered not to argue the client out of the decision but rather as a way to promote the client's self understanding. If the client feels that the clinician respects the decision, the client may be better able to hear and assimilate the interpretations.

Thus, even if a client declines a referral, positive psychotherapeutic consequences may follow. First, the client will have gained some self understanding and learned something about the usefulness of psychotherapy for this purpose. Second, having felt respected and responded to by the clinician, the client may leave with some increased positive self-regard as well as positive attitudes toward the clinician and the clinical process. Although the client may not have found relief for the presenting problem, the clinical encounter may not be experienced as a failure. Consequently, the client may now be more likely to return for a referral at a later date when conditions, both external and intrapsychic, will have changed.

This outcome is to be contrasted with that resulting from an immediate but premature referral that exploits the client's momentary high motivation for treatment at the first session. The mental pain that motivated the client to seek help in the first place can be used to motivate the client to follow through on a referral immediately. To be sure, this method may succeed in getting the client to the referred-to clinician, but it succeeds at a cost. Because the initial strong motivation cannot be sustained, the referred-to therapy may be terminated prematurely with countertherapeutic consequences. First, the client acquires a negative attitude toward psychotherapy now associated with failure. Second, the client may be reluctant to return to the referring clinician because of the humiliation of having to admit defeat. Thus, in the long run, the client does not receive helpful psychotherapy even though in the short run a quick referral appears more effective than a more circumspect approach.

CREATING A TRANSITIONAL SPACE

Assuming that the client and clinician continue to agree on the appropriateness of a referral and the client remains motivated to fol-

low through, part of the RP may be devoted to preparing the client for the referred-to therapy. It is important to explain to the client how the referred-to therapy differs from the RP. In an intake and evaluation, the clinician is quite active in asking questions and directing the discussion. Unless prepared in advance, the client may be surprised and perhaps disappointed by the different format in the referred-to therapy, especially if it is psychoanalytically oriented.

Psychoeducation may also constitute part of preparing the client. The referring clinician can explain why the referral is being made, why a particular form of psychotherapy has been selected, and in a general way, why this specific therapist has been chosen (e.g., the referred-to clinician has special competence for this particular presenting problem). When appropriate, the client can collaborate with the referring clinician in making these choices. For example, the clinician can describe more than one psychotherapy modality, and the client can express preferences among them. Or the client may express preferences for the gender or age of a prospective therapist.

The referring clinician can also educate the client about long-term therapy. For example, if the referral is to psychodynamic psychotherapy, a brief explanation of basic concepts such as the unconscious, free association, transference, and interpretation may be helpful. For a variety of reasons, psychodynamic psychotherapists often do not do this themselves, and the client must learn how the process operates through a long process of trial-and-error.

Regardless of the type of referred-to psychotherapy, the referring clinician can make use of psychodynamic insights gained from the RP to prepare the client. Often the referring clinician can infer what defenses, resistances, and negative transferences may impede the referred-to psychotherapy. Alerting the client to these possibilities may enable the client to recognize them should they materialize even if the therapy is not psychodynamic.

In addition to education, the referring clinician can facilitate the follow-through after the second RP session by creating a ‘‘transitional space’’ for the client transferring from one clinician to another. For example, the referring clinician can expedite the transition by explaining the mechanics of the referral (e.g., how to file an insurance claim). Most important, the referring therapist and the client can explore the client’s feelings about embarking on long-term therapy and about leaving the referring clinician.

Another important component of the transitional space is contact between the referring clinician and the referred-to clinician. With the client's permission, the referring clinician can communicate with the referred-to clinician to describe the client and to confirm that the referred-to clinician agrees it is an appropriate referral and currently has time available. Minimizing delay between the referral and the first appointment with the referred-to clinician is important because delay is one of the few variables shown to make a difference in the rate of keeping first appointments (Grunebaum, Luber, Callahan, & Andrew, 1996; Hicks & Hickman, 1994; Nicholson, 1994; Festinger, Kountz, Kirby, & Kimberly, 1995). At the same time, the referring clinician can gather important practical information, such as fees and office location and ask to be informed if and when the therapy begins.

The referring clinician can then inform the client by phone that the two clinicians have been in contact, that they agree on the appropriateness of the referral, and that the referred-to clinician will hold time for the client and expects a call from the client soon. This phone call is also a good time to remind the client that in the unlikely event that the referral does not work out, the referring clinician is available for another consultation. At this point it is the responsibility of the client to contact the referred-to therapist and make the first appointment (Chiesa, 1992). This triangular communication among the two clinicians and the client helps establish a transitional space for the client by creating an indirect relationship among the three, with the referring clinician acting as the pivot.

Over the 20 years that I have been referring clients, I have dropped two practices still popular among my colleagues. First, referring clinicians frequently offer more than one name, leaving it up to the client to interview the prospective therapists and choose among them. I have found this practice to further complicate an already complicated process. Although the interviewing process affords the client additional autonomy, it also permits an opportunity for resistances to emerge, especially among clients with obsessional characters. At the end of all the interviewing, the client may be no better off than before. Consequently I have come to prefer recommending just one therapist and instructing the client to contact me if the referral is unsatisfactory.

The second practice is that of meeting with the client for a session after the client has met with the referred-to clinician. Although this provides the referring clinician with helpful feedback, I have found it

to be counterproductive. For one thing, much of what is said by the client should be said to the referred-to therapist, and the follow up session can come to function as a forum for acting out. In addition, the follow-up session can reinforce the fantasy that the referring clinician is still in charge of the case. Because clients inevitably report not only on their reactions to the referred-to clinician but also on what the referred-to clinician has said and done, the follow-up session can easily appear to the client to be a review of the referred-to clinician's performance. Similarly, the referring clinician may succumb to countertransferential feelings and begin to judge the referred-to clinician's skill or fantasize how the first session could have been better handled. Consequently, I forgo a follow-up session and instead request that the client phone me 6 months after therapy has begun to report on how the therapy is going. However I must confess that only a handful of clients ever do this. Therefore, I must rely on the referred-to therapist contacting me to inform me that therapy has begun and to report initial impressions.

A key to the integrity of the RP is that all parties believe that the referring clinician has made the referral solely on the basis of what is best for the client. This means that the referring clinician must become aware of and overcome any unconscious motivations involved. After all, in referring a client, a clinician is bestowing a serious financial and professional gift on another clinician. This reality can stimulate conflicts associated with giving, gratitude, and reciprocity, and the referring clinician's neutrality may be compromised.

A well executed RP can enhance a sense of optimism and hopefulness among the three participants. After all, most clients find their therapists through word-of-mouth or by a random assignment at a clinic. They enter therapy with little sense of what is involved. In contrast, a successful RP creates a match based on knowledge of both the client and the referred-to therapist. Furthermore, the client will have already experienced some of the benefits of talking to a clinician and will have been prepared to enter long-term therapy. These positive feelings can help the therapy get off to a good start.

CASE STUDY

To illustrate my recommendations for a RP, I present a case study with the details changed to disguise the client's identity.

Molly was a 25-year-old graduate student in chemistry who came into the mental health center because of feelings of stress and depression. She reported that her research was not going well and this both depressed her and increased the pressure on her to succeed in her program. Yet, her depression made it harder for her to work, and she was thus trapped in a downward spiral of stress, depression, and failure. She displayed an obsessional character, and it was difficult for her to decide how to proceed or attend to a larger psychological picture of herself outside of her work.

Despite her emphasis on depression and stress, what was most striking to me was feelings of shame that she hardly mentioned. During the course of the first interview I learned that she was so ashamed of her research performance that she had nearly stopped going to the lab in order not to be seen. Similarly, she would not ask a professor for advice because of her profound shame. She obsessed about her failures and was paralyzed from action. This in turn deprived her of the encouragement, advice, and stimulation of colleagues and advisors. I further learned that this pattern of shame, withdrawal, and the seeking of psychotherapy had also occurred twice before when she was an undergraduate at a prestigious university. In the second instance, when her academic performance did not match her expectations in one course because of illness, she stopped attending classes, thus assuring that she would fail the course. At the urging of her professor, she sought psychological counselling at the university health center. The psychiatrist she saw recommended that she enter psychotherapy. However, when the new semester began, she again did well academically, felt much better, and did not follow through on the referral.

Now for a third time, she was seeking counselling at the urging of a professor who recognized her psychological distress. She declared that she wanted psychotherapy and was ready to pay for it. Although I believed she could benefit from psychotherapy, I was reluctant to comply with her request for a referral. For one thing, she showed very little self understanding and did not see how her past history, her personality, or her feelings could be responsible for her current suffering. Consequently I believed that she was seeking therapy not because of an understanding that something in her intra-psychic world was awry. Rather, she was desperately trying to improve her school work and as a step in that direction she was carrying out the instructions of her professor that she should seek counselling. Given this set of mo-

tives, it was not surprising that she had a history of wanting therapy when she was in distress because of poor academic performance but having no motivation whatsoever for self knowledge when her grades were good.

I felt that a referral at this point would not be effective because I believed it likely that her previous pattern would recur. She would obsess about whether to follow through on the referral, during which time her work would gradually improve, and she would lose all incentive to begin or continue in therapy. Such an outcome, I felt, would be detrimental in the long run because it would make her less likely to return to the mental health center when she would inevitably need help again. I explained my thinking to her, and she seemed accepting of my interpretation. Accordingly, instead of making a referral, I suggested to her that she try to confide in her boyfriend about what she was struggling with and that she schedule a meeting with her professor to solicit his ideas about improving her research.

Two weeks later she returned for a second session reporting that she had taken up my suggestions and was feeling somewhat better. Although her research was still not progressing, she was nevertheless hopeful. By this time she was ambivalent about accepting a referral for long term therapy, and I suggested that she return in a month for us to see how she was doing. A month later she did not show up for her appointment, and I phoned her to discover, not unexpectedly, that her work was proceeding well, she was feeling fine, and felt no need for psychotherapy.

Nearly a year later she appeared in my office with the very same set of presenting problems. Again her research was foundering, she was depressed, not working, experiencing shame, and obsessing. Once again, she asked for a referral for therapy. I judged that her distress was not as acute as the first time I saw her and that a referral would again not be effective. Therefore, instead of a referral, I reviewed with her the steps she had taken on the previous occasion to improve her circumstances, and I urged her to try them again. I again explained why I thought a referral was not a good idea, and I suggested that if she really wanted to begin psychotherapy, she should come back to see me for a referral when her work was going well and she was feeling fine. Of course, I also told her to return if her problems became more serious.

Three months later she returned, but this time, not in a crisis. She

reported that indeed several weeks after our last meeting her work had improved along with her mood and she had felt no need for psychological help. However, in the ensuing months she had thought about our conversations and had come to recognize the emotional patterns of the previous years. She decided that she wanted to understand why these cycles occurred and to prevent their recurrence. For the first time, she wanted to try psychotherapy even though she was not currently depressed. I made the referral, and she followed through. At a three-month follow-up I learned that she was still in therapy.

This case study illustrates several points. First, it shows the importance of timing and the advantage of a cautious approach to RP. I am convinced that had I made the referral after the initial sessions, Molly would not have followed through, as had happened twice before, and I would never have seen her again. Instead, I gave her the opportunity to observe herself over an extended period of time without driving her away with an unsuccessful referral. This resulted in her decision to seek therapy on the basis of some self understanding and not because a professor or psychologist told her to do so. Second, the case illustrates how the forces responsible for the presenting problem can also interfere with the RP. Just as shame and obsessiveness about work brought on the presenting depression, so did those factors interfere with Molly's ability to follow through on two previous referrals. By interpreting her resistances, I was able to help her overcome them.

CONCLUSION

I have tried to describe and illustrate some aspects of the RP in a university mental health center setting that I believe can contribute to its success. For the most part, my recommendations require a good deal of clinical judgment. As in all clinical practice, conducting a good RP is a skill as well as an art, requiring an understanding of the subtle psychodynamic forces operating during the process.

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