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Dislikable Clients or Countertransference: A Clinician's Perspective

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Abstract

Dislike of one's clients is a problem many clinicians encounter and it can have a drastic negative impact on client-clinician rapport, as well as the intervention outcome. Reasons for dislike can be varied and are not clearly known, as little research has been done on the topic. The purpose of this pilot study was to begin to understand how clinicians experience and navigate dislike for clients in practice. The study yielded critical information regarding the factors that influence dislike and the coping skills utilized by practitioners to counter or ameliorate such feelings. Recommendations for practitioners are provided, including a better understanding of feelings of dislike for one's client outside of the countertransference framework of understanding.

Keywords

Disliking clients; negative countertransference; challenging personalities; avoidance; clinical supervision

INTRODUCTION

In a recent series of studies, the National Institute of Mental Health (NIMH) determined that in the United States alone, roughly 13.4 million adults and 37.7 million children attend treatment on an annual basis for mental illness (NIMH, 2008). In addition, in 2010, the U.S. Agency for Healthcare Research and Quality found that 12.4% of the 95 million emergency room (ER) visits in the United States were for the purpose of receiving mental health services (AHRQ, 2010). Recent studies have also shown that clinical interventions have a positive effect in diminishing distressing symptoms in clients (Minami et al., 2008; Shedler, 2010). While there are many theoretical orientations and types of clinical interventions, clinicians agree that the chief goals of these interventions are to enhance coping mechanisms and symptom management in their clients (Bergin & Garfield, 1994; Laskowski, 2001; Scheela, 2008). In fact, Flückiger and colleagues (2012) found that the quality of the therapeutic relationship is a key factor in positive treatment outcomes for clients. These findings point to a need for understanding possible disruptions to the therapeutic relationship that could negatively impact client progress.

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This article attempts to answer several questions. First, the authors examine the existent literature on the therapeutic relationship, paying careful attention to its effect on the quality and outcome of treatment. Second, the authors examine existent literature on blocks to a positive therapeutic alliance, and how previous authors have suggested overcoming these barriers to effective treatment. Finally, the authors present the findings from a qualitative pilot study in which clinicians were asked about experiences of dislike toward clients or clinical situations.

Clinicians' personal experiences during treatment affect both engagement and treatment outcome (Bergin & Garfield, 1994; Carmel & Friedlander, 2009; Fosshage, 2007, 2011; Flückiger et al., 2012; Marmarosh et al., 2009; Ryum, Stiles, Svartberg, & McCullough, 2010). One of the clinician-related factors that can affect treatment outcome is countertransference, specifically the issue of disliking one's client. However, very little is known about how exactly dislike of one's client affects therapeutic alliance. It is clear, however, that the therapeutic alliance (TA) directly affects treatment outcome (Handwerk et al., 2008; Ryum et al., 2010). In addition, recent studies have shown that negative personal reactions to clients have an adverse effect on treatment (Fauth, 2006; Harrison & Westwood, 2009; Hofsess & Tracey, 2010). These findings indicate a correlation between negative experiences of the clinician with a client, clinician-client rapport, and treatment outcome. For this reason, research is needed to examine how clinicians overcome these situations in order to strengthen treatment and effect positive change.

Purpose of the Study

The purpose of this exploratory pilot study was to identify the factors that contribute to dislike of a client, and to begin to understand some of the coping skills implemented by clinicians to ameliorate this experience. Qualitative interviews with clinicians were conducted in order to identify clinician experience of these factors. Informants were asked to respond to questions regarding client dislike and coping skills used, giving them an opportunity to discuss their responses at length.

LITERATURE REVIEW

Countertransference

Classically, countertransference (CT) has been used to describe the clinician's emotions toward a client, typically unconscious in nature, and often a result of displaced emotions, stemming from the clinician's previous life experience, and having a detrimental effect on the relationship between clinician and client (Fauth, 2006; Gelso & Hayes, 2002; Hofsess & Tracey, 2010; Winnicott, 1975). There are two types of countertransference: negative and positive. Positive countertransference may be used to some benefit in a therapist-client relationship. However, this article focuses on negative countertransference and its impact on the therapist. In recent years, CT definitions identified it both as conscious and unconscious negative and positive emotions, reactions, and experiences of the client (Fauth, 2006; Gelso & Hayes, 2002; Hofsess & Tracey, 2010; Laskowski, 2001; Wachtel, 2008). This definition allows for an umbrella term that includes more clinical experiences, from annoyance at a repeatedly late client, to a clinician's possible difficulty hearing repeated stories of trauma

from clients. Authors agree that a clearer and more measurable definition of CT needs to be developed (Fauth, 2006; Gelso & Hayes, 2002; Hofsess & Tracey, 2010; Ryum et al., 2010).

Fosshage (1995, 2007, 2011) has made several critical contributions to the study of negative countertransference. Fosshage (2011) discusses the evolution of the discussion of CT over time. While Freud's original conception of CT was a positivist analysis in which the analyst or clinician took an objective role in analyzing the client, free from subjectivity due to scientific rigor, later authors have all agreed that just by being involved in the observation, the analyst brings biases and personal factors to the table which affect both his or her observation and the individual being observed (Fosshage, 2007, 2011; Mitchell, 1988; Wachtel, 2008). Most importantly, the very act of listening to a client is filtered through what Fosshage (2011) terms the "analyst's self-perspective." The process of listening for the clinician is a process of listening to his or her own reactions to the client. How the clinician listens will be based on personal and historical factors. In this way, negative CT becomes a process in which the clinician effectively gets in the way of treatment. These authors also found that the definition of CT has historically been limited to the clinician's understanding of the client's transference, rather than including the clinician's own independent reactions to the client and the clinical relationship.

Countertransference and Treatment Outcome

As with research regarding negative CT and client-clinician rapport, current research has found a link between training and treatment outcome (Bergin & Garfield, 1994; Gold & Hilsenroth, 2009; Harrison & Westwood, 2009; Minami et al., 2008). These findings are very important, as they allow us to understand a factor in how clinicians might mitigate experiences of negative CT. Gelso and Hayes (2002), in particular, found that the training used in supervision is a key factor in managing CT. However, the components of training in and out of supervision, and how this training might allow clinicians to minimize the effects of negative client experiences on the treatment, needs elaboration.

Although the phenomenon of CT is widespread and has been discussed extensively in psychodynamic literature, the discussion of its factors, effects, and especially its management, is limited (Fauth, 2006; Gelso & Hayes, 2002; Hofsess &Tracey, 2010). More information is needed to understand the specific client factors that most often create negative CT for clinicians.

The dynamics of the therapeutic relationship are integral to treatment and, therefore, treatment outcome. Whether the clinician is experiencing hatred, dislike, or countertransferential displacement, researchers agree that the intervention will suffer, because the therapeutic relationship will suffer (Buckley, 1986; Hoit, 1999; Mitchell, 1988; Mitchell & Black, 1995; Rothstein, 2006; Slochower, 2003). However, as the authors have seen, discussion to date on this topic has often been mired in analytic terms, and has not evolved to describe more universal clinical experiences, specifically in treatment models not based in psychodynamic theory. The lack of discussion of CT outside the sphere of psychodynamic practices means that wide ranges of clinicians are not being exposed to CT literature and theories of alliance.

Conceptualizing Dislike in Clinical Practice

Frequently, dislike of a client has been viewed as a component of the experience of CT (Alves de Oliveira & Vandenberghe, 2009; Brosi & Carolan, 2006; Mitchell, 1988; Ro & Wampler, 2009; Slochower, 2003; Wachtel, 2008). This definition misses negative experience of one's clients created solely by something in the client, whether it is consistent lateness or a history of untreated trauma affecting the client's relational behaviors. Winnicott (1975) was the first author to define these feelings as "dislike" of one's clients and openly discusses its impact on treatment. While he describes strong negative feelings toward one's client, he limits this possibility to working with people experiencing psychosis, and his only prescription is psychoanalysis for the clinician. These discussions of CT lack a detailed discussion of the spectrum of negative reactions to clients, coping mechanisms used by clinicians to manage these emotions, and how management (or mismanagement) affects treatment. However, Winnicott and those discussing his work have been the first to call a horse a horse and write about disliking the horse that you are treating. Some authors have stated that literature steeped in psychodynamic language can be alienating for those not educated in or familiar with this modality (Bergin & Garfield, 1994; Wachtel, 2008). As educational institutions increasingly offer training in behavioral and cognitive modalities, clinicians are poised to become even less acquainted with this dialogue.

Another difficulty in determining a definition of CT that can include dislike is the lack of understanding of whether the two phrases describe different experiences. Classical understanding of CT as displacement does not allow clinicians to understand the entirety of the clinical significance inherent in disliking one's client. This distinction is important, as working with displaced emotions is a different process from working through genuine blocks toward the client based on clinician reaction to the client (Alves de Oliveira & Vandenberghe, 2009; Brosi & Carolan, 2006; Mitchell, 1988; Ro & Wampler, 2009; Slochower, 2003). Is it possible that one dislikes a client simply for their presenting attributes and personality rather than them unconsciously reminding us of negative experiences with other people in our lives? What remains to be culled from current knowledge is what are the factors comprising the experience of disliking one's client and the coping mechanisms utilized by clinicians to manage these emotions.

Definition of Dislikable Clients in Clinical Practice

For the purposes of this study, "dislikable clients" will refer to those clients who have qualities that would produce negative reactions, emotions, and experiences for most clinicians—such as obstinacy, being irksome to the therapist, threatening, or resistant to advice, change, or clinical input. "Dislikable clients" will also include those clients who might not produce dislike in other clinicians, but for reasons of CT—classically understood as displaced reactions stemming from the clinician's experience—do, in the particular clinician being questioned (such as one who might say, "He reminds me of my uncle. I hated my uncle").

METHODOLOGY

Study Design

This study employed an exploratory, qualitative research design to assess the experiences and perceptions of five clinicians from three different disciplines with regard to dislike of clients. After receiving institutional review board (IRB) approval, in-depth interviews with the five informants who have extensive experience in the mental health field were conducted to develop a fuller understanding of this complex phenomenon.

Sample

This study employed purposive sampling methods in order to find informants for interviewing in the New York City area. The five informants were two psychologists; two clinical social workers; and an emergency room physician (not a specialist in mental health). Table 1 provides a detailed description of the sample. Informants were chosen based on the following inclusion criteria: at least five years of postgraduate field experience; work within the New York City area; and are knowledgeable about the dynamics of helping others. The authors identified five individuals who met the criteria through current and former professional relationships with these individuals. An e-mail request was sent out to these individuals to consider participation in the study. The informants in this study were the five professionals who agreed to participate in the study.

Data Collection

Informants were each interviewed separately, after securing informed consent. The interviews were recorded digitally, and then transcribed for coding by the researchers. Informants were each asked a series of open-ended questions predetermined by the researchers. The questions were designed by the authors to allow the informants to recount a detailed, descriptive summary of their experiences with clients whom they had disliked. The questions asked for general demographic and professional histories, experiences with “dislikable” clients, the clinicians’ input on whether and how these reactions affected treatment, any themes or commonalities in the cases, and how they coped with these issues. The questions were developed in accordance with the practice experiences of the two authors. The informants were then asked whether they had any regrets or thoughts on how the treatment fared, and whether they had discussed these cases with others. Each interview lasted for 45 minutes to 1 hour, and was transcribed so as to be coded by the researchers. The interview questions are provided in the Appendix.

Data Analysis

Author #1 is a licensed master social worker with five years of experience working with individuals, families, and couples of all ages. Her clinical expertise is in trauma, addiction, and working with children and adolescents. In addition to her clinical work, Author #1 is a doctoral candidate, as well as an Adjunct Instructor of Social Work.

Author #2 is an Associate Professor of Social Work and a licensed clinical social worker. He has gained nearly 15 years of professional experience in the mental health field, specifically

individual and group counseling with clients with severe and persistent mental illness, in inpatient and community-based settings.

The authors used an iterative process to analyze the interviews and identify a broad range of themes pertaining to informants' understanding of the process and nature of dislike in clinical relationships. The open-ended responses were coded using open-coding techniques suggested by Corbin and Strauss (1990). This process included independent reading and coding of the transcripts to identify themes, comparison of themes between investigators, and refinement of themes via consensus-building discussion (Corbin & Strauss, 1990). In the open coding phase of data preparation, the authors generated 19 unique codes. The next step was distillation of those codes based on relatedness, shared meanings, overlap, and definitions into two major themes. The two themes identified were factors affecting dislike and the coping skills utilized by clinicians. Table 2 describes the thematic topics and the corresponding codes.

A member-checking process was subsequently used in which two informants reviewed the analysis to provide opinions as to whether their views were appropriately represented. The two informants were selected based on their prior experience with qualitative data analysis and availability. Lincoln and Guba (1985) describe member checks as "the most crucial technique for establishing credibility" (p. 314) in a study. In this way, the informants may add credibility to the qualitative study by having a chance to react to both the data and the final narrative (Creswell & Miller, 2000).

FINDINGS

The analysis of data yielded critical information regarding the nature of dislike, factors that contribute to dislike among therapists, and the variety of methods employed by them to cope with their intense feelings of dislike.

Factors Affecting Dislike

One of the major issues that contributes to dislike of clients as identified by the interviewees was the questioning of the therapist's capabilities by a client. The therapists felt challenged by the clients to prove their professional expertise and ability to deal with the client's issues.

> …and she feels like her standards are very high, no one can ever meet them. So when I start to analyze that with her and say, "Well, tell me what it's like to be with me, and feeling like I'm not meeting your expectations," she gets irritated, because she doesn't want to explore what's underneath the obvious. She wants to stay with her task list and question whether I can actually help her…. I feel defensive, and when I get defensive I want to say to her, "Wait a minute. I have three graduate degrees." (Female Psychologist)

This issue of questioning professional abilities becomes even more critical when the client is a therapist seeking professional help from a fellow therapist.

> …she [client] is a very high-powered psychiatrist, so she's in the profession, which makes it a little bit difficult, because she's very, very well-known and she's very

> seasoned, and she knows what she's doing, and she wants to micromanage me. (Female Psychologist)

Another issue that contributed to dislike of clients was when the clinician felt that clients were not making progress or meeting goal milestones at the pace the clinician felt was acceptable. This made the therapist feel like they were not in control or that they were being micromanaged by the client.

> I have this client who is so resistant. I think she is aware but I don't think she's willing to change. I think she's afraid to let go of that control. She's very controlling and she's afraid to let go of that. They want to be in charge and in control of what's going on. (Female Psychologist)

Sometimes clients went so far as to tell the clinician that it is the clinician's responsibility to fix the problem for the client.

> A lot of people… what you see, they sit down and they want you to tell them what to do. They want you to fix them. And that's not the way it works. (Male Psychologist)

All five interviewees highlighted the issue of perceived safety (on the part of the clinician) as a significant issue contributing to dislike of clients. In other words, if the therapists felt emotionally insecure or physically unsafe with the client, they were more likely to develop strong negative feelings toward the client. In relation to safety, belligerence, verbal challenges, and physically intimidating behaviors were identified as contributing to a growing dislike of the client.

> When you dread going to work every day. When you, like, hop on the subway or you hop in your car, whatever, and you're going to work, and you're like, "Not this patient again."(ER Physician)

> I mean, after he threatened me physically I actually don't think I would allow myself to go down certain roads again. I think maybe it limited the interventions I was doing with him, like the depth of where I would go with him, because I was afraid if I got into these deep places of anger towards his mother that he'd snap again, 'cause he would get in these blind kind of places. (Female Psychologist)

Another clinician reported feeling nervous around much older clients. He mentioned how being much younger than his clients who were dealing with a significant life crisis, such as HIV, was intimidating.

> …they gave me a caseload of thirty-five adult males, all of them were older than me. My youngest client—I was twenty-seven, my youngest client was thirty-two, my oldest client was sixty, and eleven of them were HIV positive, and in 1986 that was a huge deal, and I found it really intimidating. (Male Social Worker)

It appeared that the development of dislike could be instantaneous (based on certain presenting characteristics) or result from a slow build-up of negative emotions toward the client as the treatment progressed. As the client continued to challenge the therapist, put them on the offensive or test their patience, the dislike seemed to grow concurrently.

> …we started out fine at first… but she was so resistant to change—everything I offered was met with a negative response. The more she resisted… I grew frustrated and started to dread our sessions. I was actually relieved when she left. (Female Psychologist)

One clinician explained how he took an instantaneous dislike to his client.

> …but she was like—she was working my last nerve, because she didn't—she was —there was something wrong, she just initially rubbed me the wrong way with her attitude… it was so belligerent, I don't know what—the people that you want to hit, you know you'll see this if you do clinical social work in a hospital or an ER. (ER Physician)

With reference to characteristics that contribute to instantaneous dislike, all five interviewees identified specific categories or types of clients that they disliked. These categories could represent a specific disorder, such as personality disorders, or a type of personality, such as belligerent individuals, or a demographic characteristic such as age or gender.

> I can't deal with personality disorders, and the three worst of course—the borderline, the narcissist, and the sociopath… the Axis 2 disorders. (ER Physician)

> Narcissistic people. It's just really frustrating to me to try to sit down and talk to somebody, it's like you're talking to the wall. 'Cause you tell them something and they just like start talking about something about themselves, you can see they're not relating whatsoever to what you're saying. (Male Psychologist)

> Teenagers—you know, there are one or two that were really great, that were really pleasant, but most kids didn't want to do anything. They didn't want to talk. They were belligerent and then their parents, forget about the parents. (Male Social Worker)

Sometimes clinicians cited frustration about the lack of progress in their work as the basis for dislike of a client. They felt that the client's sense of self-awareness was so impaired that they lacked insight and made the clinician feel frozen.

> Sometimes I just find them to be boring, like they're just really lacking in feeling and lacking in self-sense and it's just like—or they say things that I just, or sometimes they're just doing things… and I can't tell them not to do it, and sometimes I want to shake them. (Female Social Worker)

Coping Mechanisms for Dislike

Negative Coping Techniques—Unfortunately, the most frequently cited coping skills mentioned were negative. These coping mechanisms did not frequently include supervision that the process literature points to repeatedly as the correct method to manage negative CT's intrusion on treatment. One of the most common methods mentioned of coping with a client that the therapists disliked was to transfer or refer the client to another therapist. They would reason that another professional would better serve the client.

> I walked away, I walked away. You know I walked away and I left her—I had a Spanish-speaking person—they call them a liaison. You know, they come and sit with patients, and I said to her—I charged that person with the responsibility…. (ER Physician)

> I thought to myself… "What should I do? I mean, should I refer, transfer the case? Because it's just killing me. I just can't deal with her." (Male Psychologist)

In other instances, the therapist would try to convince himself or herself that they could forego the income provided by a potential "dislikable" client in lieu of some peace of mind and limited hassles at work.

> I have a thriving practice. I don't need her financially. I don't need any of my clients, which is a good thing, so I want what's best for her, I mean that's how we should all work, but—so I said to her, "You should go around and shop around; you have to feel comfortable." (Female Psychologist)

All five interviewees used agency policies and procedures as a crutch to deal with clients they disliked. They felt this was the only way to minimize conflict or resistance from clients.

> I had a couple who were just so difficult… so I discussed the rules—where it was great because I helped them look at it in a different way, and resign themselves to the fact that here is where they were and here's what the rules are and what they need to do. (Male Social Worker)

Another critical issue related to coping was the manner in which therapists intellectually processed their dislike and accordingly responded in clinical scenarios. With reference to negative coping skills and responses, they all utilized a variety of mechanisms, such as blaming the client for contributing to the dislike, labeling clients as inherently difficult to work with, controlling or minimizing empathic responses toward clients, and instilling fear in clients if they were noncompliant in order to help themselves (clinicians) deal emotionally with the challenging situations.

> …they are very inappropriately needy, and have very poor social skills, so the only way they know how to interact is through conflict.(ER Physician)

Name-calling was quite frequent among some clinicians and highlighted the blaming of the client as the source of the problem(e.g., "After all… he's the jerk" [Male Social Worker]). Interestingly, one of the informants described clients as predatory—waiting to pounce on the weaknesses of the clinician.

> It's harder to find their strengths because they're like these piranhas that are waiting for you to slip up so that they can come in and criticize, basically. (Male Psychologist)

The interviewees felt that it was difficult to empathize with a client they disliked and they struggled with their ability to respond to the client in a professionally appropriate, competent, or positively affirming manner. All five recognized the negative implications related to their lack of empathy and understanding, but felt that it was the client who had pushed them into a space where they felt emotionally drained or angry.

> Sometimes I am at a loss… yelling back is the only thing that I can do. I think I've done it a couple of times and it always feels worse afterwards, and that's—after thinking about it over and over and talking about it… that's exactly what they want and deserve. (ER Physician)

> Sometimes it's people that I see they just don't care about, you know, getting help. They're there 'cause, you know, their parents bring them, or because the system brought them here, ACS or the court or whatever, and they're sitting and, "I really don't know," and we're just sitting there wasting our time." (Male Psychologist)

> I think I kind of shut down, and I'm just like, I don't—like, I just kind of tune out and I'm like, "Uh-huh, uh-huh, uh-huh," and I feel guilty about it because I'm, like, we're not doing any work, and they'll, like, pop in, and then I'll hear something, like I'm listening but like kind of passively listening. (Female Social Worker)

Of particular note and troubling concern was the use of intimidation by the clinician to control the client's behavior. In some instances, the clients were humiliated or reminded of the power wielded by the therapist in order to gain their compliance or reduce their antagonism toward the therapist. In other cases, clinicians were aware of breaking with clinical models out of dislike for clients or clinical content.

> …tell them, "Stand up," and then just blow them in the wind right in front of the whole dining room for something they did, and then finish it with, "Now, sit down, stupid." (Male Social Worker)

> I think it's because I'm too strong with the parents, too tough. And there's just, like, it comes to the point when I'm just like—do what I say—I mean, I'm, like, "Do you really want to do this? 'Cause, I mean, clearly you're not doing what I told you to do, or what I advise you to do…." (Male Psychologist)

Positive Coping Techniques—On a positive note, there was some discussion of appropriate coping mechanisms. Some clinicians perceived difficult clients as a welcome challenge, even as a relished part of their work with clients.

> So I found that really frustrating with him at times, but it was also a kind of a delicious challenge. Because at the end of the day they go away, and all I have is who I see in the mirror…. (Male Social Worker)

Some clinicians reported that they attempted to empathize with their clients by developing an understanding that the client's negative behaviors were an integral component of their maladaptive coping skills.

> I knew AA really well so I could talk to him about, you know, what kinds of jackpots his anger could get him into, and when he directed at me I know it wasn't about me, and so I, you know, finessed it by understanding where it was coming from, and trying to help him to see that when he was acting angrily or aggressively towards me it wasn't me that he was doing that at, that it was his frustration at his own situation. (Male Social Worker)

> Teenagers are hostile but they're not critiquing and criticizing what you're doing 'cause they realize that you're an expert at what you're doing but they just don't like being with you; it's a different feeling.(Female Psychologist)

They also reported that working with dislikable clients was made easy if the clinician was passionate about the population he or she was working with.

> I actually have loved, I mean I love the kids, I love teenagers. I like kids. I like working with kids, they're awesome, even at the—a lot of them at the beginning will challenge you and be—you know, they'll test you. (Female Psychologist)

The final positive coping mechanism mentioned was the concerted effort by the therapists to try to build a strengths-based therapeutic alliance with a client they disliked. They highlighted the importance of locating strengths within their clients that they could affirm, build upon, and utilize to gain the support of their clients.

> I mean, I feel like to a certain extent both of these clients need to be shored up and need to be told that they have a lot of strengths and that they're doing the best they can, given the situation…. So I really try to look—even though it's hard to find the strengths, I try to look for the strengths in them, and say, "You know, you obviously really love your son or you wouldn't be here." (Female Psychologist)

> …and I'm always—I really think that even if you dislike a client if you play to their strengths and if you play with all the advantages they bring with them to the table… things can go well…. (Male Social Worker)

The therapists utilized this strength-based perspective and an empathic understanding of the clients to motivate the clients to change their maladaptive behaviors. They reported that this significantly decreased client resistance, minimized dislike, and allowed the therapist and client to work successfully toward mutual treatment outcomes.

> …my posture with them was to encourage them to take responsibility for their experience… only way for them to work around whatever they're experiencing is to take responsibility. And the couple that I was able to accomplish that with, that was a real challenge for me. I had to put a little star next to my name on the fridge. I took training in motivational interviewing. (Male Social Worker)

Challenges to Addressing Dislike

There were several issues mentioned by clinicians that address the issue of challenges to working through or becoming aware of dislike. The most common challenge to addressing dislike stemmed from economical concerns.

> Yeah, it affects my work because I don't want to work with them. It's like every time I'm sitting there waiting for them it's like I don't want them to come. The only reason why I want them to come is then I get paid, even though it sounds horrible but it's just the way it is. (Male Psychologist)

> And then maybe I was starting to get negative feelings because they weren't coming, like I said that's a big part of when I get very frustrated when they don't

> come, even if they are difficult… mainly 'cause that's what my salary is dependent on. (Female Social Worker)

Another challenge for clinicians was the effective use of supervision to deal with dislike. Only three clinicians reported using supervision regularly and reported that it could be both helpful and a block, due to the often dual nature of clinical supervisors. They reported that they had not discussed the issue of dislike with their supervisors. Clinicians felt that if they shared their issues surrounding dislike, their supervisors (who may also be responsible for administrative and personnel decisions) may react negatively.

> But she does write my evaluations, and it means… do I look good or bad or whatever, and I don't want to be misunderstood, so sometimes I'm not as—how you say—um—honest with supervision. (Male Psychologist)

Another clinician found a similar scenario, but with fellow clinicians, creating a barrier to utilizing peer support to manage dislike. The challenge presented was one of peer competition, another dual role in the workplace.

> We're colleagues, we're all gonna want to go into private practice one day, we all want to be like we're the best clinician, nobody wants to share their deficiencies, they want to share how great they are. So even my talking to you right now, it's like, "Oh, my God, she's gonna feel I'm deficient." (Female Social Worker)

Both of the scenarios just described point to insecurities among clinicians as being a difficult barrier to managing, or even being aware of, dislike.

> …but I feel insecure because I—it's not what I'm used to, it's not [in] my little box of, you know, being a therapist." (Male Psychologist)

IMPLICATIONS

This study has raised several implications for clinical practice with regard to managing dislike of clients in psychotherapy. What the authors found was that the informants were often unable to identify their negative feelings about clients as CT. This may be due to the varied training and education that they may have received (Bergin & Garfield, 1994; Wachtel, 2008). Rather, they believed their feelings of dislike were related to their professional experiences. This was in line with the findings of other authors cited in this article (Bergin & Garfield, 1994; Carmel & Friedlander, 2009; Fosshage, 2007, 2011; Flückiger et al., 2012; Marmarosh et al., 2009; Ryum et al., 2010). In other words, the clinicians externalized the issue by pointing to specific attributes and behaviors of clients as the cause of their dislike. Being physically threatened by the client may lead to fearing the client, which may contribute to dislike. However, some of the reasons for dislike offered (e.g., being questioned about one's capabilities or feeling intimidated by a client from a psychotherapy background) may point to feelings of inadequacy that may stem from negative CT (Handwerk et al., 2008; Ryum et al., 2010). Similarly, feeling frustrated by clients who appear resistant to change or unwilling to engage in their own treatment may reflect a clinician's own insecurity with their abilities. On the other hand, frustration with clients who pose challenges may simply allude to the fact that the clinician is experiencing burnout or has limited patience given the multiple pressures on his or her time. However, the

educational training of the clinician, psychodynamic versus cognitive behavioral, interpersonal therapy, may influence one's perception of these experiences. Better use of supervision might also minimize these effects on treatment. The informants did often bring up supervision as a supportive factor, indicating that for these individuals, supervision did not serve its intended purpose. Supportive supervision, in addition to educational and administrative supervision, is a critical factor in informants feeling validated emotionally. Support could come from supervisors as well as the team but needs to be offered in a consistent and systematic manner to be effective.

Based on the findings of the study, the following are issues that require careful consideration:

- *Labeling certain types of clients as difficult or instantly dislikable*: While it is understandable when clinicians are physically intimidated by a client and fear for their safety, the issue of broadly classifying certain types of clients (clients diagnosed with personality disorders, mandated, or belligerent clients) as dislikable is troublesome. Another type of client cited as dislikable was a fellow professional seeking help. This type of labeling may handicap certain clients even before they begin treatment, thus affecting outcomes. This issue raises the question whether some individuals are just impossible to treat, or if they require a specific kind of expertise and training on the part of the clinician. One must also consider whether it is ethical to paint certain types of clients with a broad, negative brushstroke or for clinicians to distance themselves from such clients, right from the start, in order to prevent further harm.
- *Giving up on, or passing the buck on, certain dislikable clients*: Another concern for practice is determining what is in the best interests of the clients. Some clinicians reported that they would try to refer a "dislikable" client to another professional or avoid serving them altogether. This raises a critical issue of a clinician's ethical responsibility to those who are seeking help (whether voluntary or mandated). Does referring a client that one does not like or considers difficult constitute a breach of ethical responsibility? One could argue that referring the client to someone who is better suited to working with the client is in the client's best interests. In that case, the clinician to whom the case is transferred and the process utilized requires due diligence. If a clinician simply transfers cases to less experienced or junior staff members, such a transfer would not be in the best interests of the client and may even jeopardize his or her mental health. An ethical and systematic process of transfer would require that a clinician identify fellow professionals who are experienced and skilled at working with the type of clients being referred. A final concern is the total avoidance of service to certain types of clients. We recognize that clinicians involved in "private practice" may have more leeway than those employed in community-based agencies where selection of one's clients is not possible. Independent clinicians may have more autonomy of the selection of clients they choose to serve. However, this once again raises questions about the responsibility of clinicians to clients in need who seek out their service. Do these clinicians ethically and responsibly refer the clients to a fellow

professional, or do they simply offer excuses for refusal of services (such as lack of time, too many clients, etc.)?

- *Empathy and patient understanding can serve as effective buffers*: One of the recurring themes that encapsulated positive coping skills employed by clinicians when working with "dislikable" clients was the utilization of empathy. While the development and use of empathy are important therapeutic tools in clinical practice, practitioners struggle with it when confronted with "difficult" or challenging clients. In addition, counter-transference may further imperil the development of empathy in such therapeutic relationships. But most of the clinicians in this study expressed attempting to step back from the situation and trying to understand the client's perspective. While expressing their struggle to remain empathic, the clinicians highlighted how empathy helped them deal personally with their negative feelings toward the clients. In line with Fosshage's (2011) focus on the analyst's self perspective, clinicians may need to engender and sustain empathy for the "dislikable" client. We believe that this may be one of the critical areas of focus in supervision and training of clinicians. Even though this issue is covered in the educational programs of all three disciplines (medicine, psychology, and social work), we believe there is a significant need for more research and targeted training in the mental health field. In addition, training for supervisors may be required to help guide and support fellow clinicians with this issue.

- *Use of supervision*: As Gelso and Hayes (2002) stated, ongoing supervision and support is critical in developing clinicians' ability to deal with CT. Three clinicians reported the use of supervision in order to deal with their practice concerns, but did not feel comfortable raising issues of dislike or CT. They raised a very important issue that may work as a detriment to them seeking help. They highlighted the negative impact of sharing their concerns on their ongoing employment prospects. Supervisors have dual roles (e.g., educational and administrative). Can the issue of an employee struggling with certain issues be used against the employee when making administrative decisions regarding case allocation, ongoing employment, pay raises, etc.? The challenge for supervisors is to create a supportive and open environment where supervisees can share their thoughts and concerns without fear of negative repercussions. Maybe clinicians should receive supervision from their more experienced peers who do not have administrative power over them. This would allow the clinician struggling with CT to feel safe and increase his or her willingness to engage in introspection. In fact, authors agree that support is an important factor of supervision (Brosi & Carolan, 2006; Harrison & Westwood, 2009; Gelso & Hayes, 2002). However, the respondents report feeling otherwise. In other words, they may like the idea of being supported but fear being evaluated negatively for seeking the support.

Another avenue for seeking advice and supporting clinicians is peer supervision. However, clinicians reported fear of being negatively judged by their peers. We believe this may happen in every field where professional teams are employed. Maybe individual supervision models, though time-consuming, might be better suited for learning about and addressing

negative CT in practice. Peer supervision could be used to discuss issues that seem nonthreatening professionally and could add to the knowledge and skills of clinicians.

The authors believe that supervision needs to be ongoing and not limited to new professionals only. Dealing with CT could occur over the entire career of a clinician, and having a system for mentoring and guidance would be critical to maintaining efficacy as a clinician. Each professional discipline in the field of mental health utilizes continuing education to maintain quality among their members. Specific curricula on CT and its impact on TA and outcomes should be developed and required for all professionals.

With respect to the themes identified by the authors, the integration of positive coping mechanisms and addressing the maladaptive coping mechanisms adopted by the informants would be significant. These issues would be a significant part of the supervisory sessions that would enhance clinicians' functioning in practice. Similarly, removing the economic barriers that make clinicians feel like they have no choice but to work with "dislikable clients" in order to keep their job or be reimbursed may be difficult to address but needs attention. Supervision and training in specific skills that could enhance clinician effectiveness might be critical.

Individual and peer supervision could be used to increase awareness of issues such as working with resistant clients, egosyntonic disorders such as personality disorders, and dealing with professional insecurities. These supervisory sessions would be strengthened if the peer groups included clinicians from different fields to enhance trans-disciplinary understanding and conceptualization of mental health practice. This would expose clinicians to varied modalities—psychodynamic and interpersonal—to allow for greater understanding of CT and its impact on practice. As several researchers have noted, working with displaced emotions or through genuine blocks toward the client is critical to client engagement and treatment outcomes (Alves de Oliveira & Vandenberghe, 2009; Brosi & Carolan, 2006; Mitchell, 1988; Ro & Wampler, 2009; Slochower, 2003).

LIMITATIONS

There are some limitations that have an impact on the generalizability of the study findings:

- One of the major limitations of the study is that the sample size was limited to five respondents. The researchers initiated this project as a pilot study to document and describe the experience of dislike in clinical work. The authors recognize that this study needs to be replicated with a larger sample size to test credibility of our findings.
- Although adequate precautions were embraced, the open-ended questions, selection of respondents, and the analysis of data may also have been influenced by the bias of the researchers.
- The sample size is too small to determine the influence of the practice discipline of a clinician on their experience of dislike and the coping skills utilized.
- Because the study included informants from multiple fields (substance abuse, medicine, psychology, and social work) as well as multiple treatment modalities

(substance abuse, medicine, cognitive behavioral, and psychody-namic) the questions asked were necessarily broad. A future study comparing psychotherapists with psychodynamic and cognitive behavioral training could examine much more deeply how training allows clinicians to deal with dislike or negative CT. How clinicians utilize and integrate supervision in their practice to deal with CT or work with dislikable clients would be helpful.

CONCLUSION

Working with clients can be difficult in many ways. From building a therapeutic alliance to developing and meeting treatment goals, there are many obstacles to successful clinical interventions. When clinicians develop negative emotions or reactions to particular clients, it can disrupt treatment. This study found that there are many factors that contribute to clinicians disliking their clients and clinical work with these clients. The authors also found that there are common coping mechanisms employed by clinicians in these situations. Some of these techniques further disrupted or even ended treatment, while other practices fostered strengthened empathy toward clients and facilitated moving forward with the helping relationship. This study was a preliminary examination of how negative countertransferential reactions affect treatment, and more research is needed in this area. The authors hope that new research will further the goal of understanding how exactly negative reactions toward clients can disrupt treatment, and what tools are necessary to work through these emotions in order to successfully deliver clinical interventions.

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APPENDIX: INTERVIEW QUESTIONS

Questions Asked During Interview	
1	What is your cultural and ethnic background?
2	Please tell me about your history as a clinician.
3	Can you recall situations where you have felt frustration or negative feelings toward a client?
4	How did these feelings affect your clinical work?
5	Can you think of any commonalities or themes between these cases? Please explain.
6	How did your training help or hinder you in these situations?
7	Is there anything you wish had gone differently?
8	Have you been able to discuss this situation with other clinicians? How did it go?

TABLE 1

Sample Demographics

Respondent	Age	Gender	Professional Discipline	Experience (length and type, population)
Respondent 1	Mid-40s	Female	Psychologist	More than 20 years
Respondent 2	Mid-30s	Male	Emergency Room Physician	At least 5 years
Respondent 3	50s	Male	Substance Abuse Counselor and Clinical Social Worker	More than 2 decades
Respondent 4	30s	Female	Clinical Social Worker	5 years
Respondent 5	30s	Male	Psychologist	5 years

TABLE 2

Interview Themes and Codes

Themes	Factors Affecting Dislike	Coping Skills
Codes	Therapist feels threatened/ insecure about client questioning abilities	Passing the buck
	When client tries to control process	Blaming
	Therapist feels physically or emotionally threatened	Labeling clients negatively according to attributes or diagnoses
	Client causes conflict/is belligerent	Hiding behind agency policies/procedures
	Therapist's intense emotional reaction to that builds up over time	Stopping empathic response to protect self
	Categorization into categories therapist doesn't "like"	Instilling fear in client for control
	Not liking a certain type of client population	Building therapeutic alliance
		Motivating the client to change "dislikable" traits/behaviors
		Understanding that "dislikable" behaviors/traits are client's coping mechanisms
		Being passionate about a specific population being served allows for empathy and knowledge-building
		Supervision and peer supervision/support
		Personal recognition of transference/countertransference