

# **What if You Just Don't Like the Person?**

## **Professional responsibilities and limitations**

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We therapists are generally supposed to be able to provide some form of helpful psychotherapy to any and all who come to us, whether in a private practice, or from a clinic's assignment, or an insurance company's referral. We are similar to medicine's g.p., the family doctor, now often called a primary care physician (pcp).

In a few cases we therapists may refer certain patients/clients to a specialist, when we judge that some specialized treatment is called for that exceeds our own training. Most of the time, however, we aspire to be "all things to all people," with a generalist's overview of all mental functioning and the repair of all emotional difficulties. We are also trained to be aware of, and to control — as part of our professional ethics — those private inner feelings that are not therapeutic.

Occasionally all this training doesn't work. Into our office comes a person who sets off wave after wave of powerful reactions within us. Sometimes we can use this "countertransference" to help us understand just how this person manages to mess up his or her life. Managing our countertransference is part of our job and, while sometimes frustrating, is useful and doable, at least in theory.

But sometimes the person who's entered our office just rubs us too much the wrong way. The person may be whiney, mean, crooked, seductive, nasty, condescending, money-grubbing, or whatever — just too off-putting or provocative for us (although perhaps not for another colleague). We may struggle for a while, with a growing awareness of how very helpless or very angry or very sexual or very (you fill in the blank) we are feeling in relation to this person.

And not only our feelings but our actions may become problematic. We may find ourselves making errors: forgetting the appointment time, the person's name, or details of the person's history; getting sleepy or needed to use the toilet more; speaking abruptly or critically or bristling at questions; gossiping to a colleague about the foibles of this new "case," thus using distancing language in referring to the person. Our reaction may be so strong that we can't control it — or we fear that we can't.

We therapists know how to deal with a client/patient who is "stuck." But if we are the ones who are stuck, even after competent supervision or consultation, and are still not able to feel good enough about ourselves, or therapeutic enough toward this person, then we face a difficult decision.

One choice is to keep plugging along, getting help from videos or books or other professionals, in the hope that we can gradually improve our complicated reactions, create a workable treatment plan, and become more therapeutic. This option has an ethical time dimension to it: how long can we "fake it

until we make it,” while we may also be sending out mixed emotional signals to the person who has come for treatment? There is no one right answer, but persistent wrestling with it should produce more clarity to us and our advisors.

The other option is to admit defeat and refer the person onward. Although this happens more frequently with inexperienced therapists, it can be an appropriate decision for any therapist, no matter how highly trained or experienced. Unfortunately our professional literature provides only a few helpful examples of therapists admitting, reluctantly, that they cannot provide what the new patient/client needs.

This kind of referral, this kind of premature termination, will usually bring positive feelings of relief to the therapist, as well as less positive ones: perhaps shame at admitting one’s limitations, or guilt at having failed to reach one’s professional ideals. Also, perhaps anger at having one’s best intentions foiled by a person we just don’t, and can’t, like.

Either choice can be hard to accept and work through. But worst, however, is the prolonged avoidance of making an admittedly difficult decision. Such therapist dithering is bad for the client/patient and equally bad for the therapist, who will only grow more demoralized and less helpful with the passage of time without a clear direction.

Coming to a clear decision and then taking action on it, whether to work harder or to refer out, will predictably improve the therapist’s bruised sense of self. The therapist will be doing the right thing about her or his “wrong” feelings, which are really all-too-human ones.

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