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What patients reject psychotherapists? An exploration of the cases - themes and personality styles - that disturb psychologists and psychiatrists in clinical work

¿Qué pacientes rechazan los psicoterapeutas? Una exploración sobre los casos —temas y estilos de personalidad— que perturban a los psicólogos y psiquiatras en el trabajo clínico

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Abstract: Although the therapeutic model is relevant in order to provide theoretical constructions that allow conceiving human problems from a particular perspective, its practical application goes through the sieve of the personal characteristics of the therapist and the particularities of the context where the model is exercised. Thus, beliefs, values, history, personality traits of the therapist modify the model, in the same way as the attention in a private practice or public hospital or the characteristics or themes of the patient. Therefore, beyond the model, it is important to talk about the "therapeutic style". Within the personal limitations that modify the model are certain patient characteristics and subjects that disturb the therapist in his free exercise. The aim of this work is to explore what are the issues (stories and problems) and the characteristics (personality traits and pathology) of the patients that generate rejection of Argentine psychotherapists (psychologists and psychiatrists), taking into account other variables such as years of professional exercise, attention area, gender and therapeutic model. A transversal and descriptive-correlational study was carried out through surveys. The main results were that the subjects that generated absolute rejection in the therapists were the torturers, abusers, murderers and criminals.

Key words: gender, patients, professional practice, psychotherapy, therapeutic style

Resumen: Si bien el modelo terapéutico es relevante a los efectos de brindar construcciones teóricas que permitan concebir a los problemas humanos desde una perspectiva particular, su aplicación práctica pasa por el tamiz de las características personales del terapeuta y las particularidades del contexto donde se ejercita el modelo. Es así que las creencias, valores, historia, rasgos de personalidad del terapeuta modifican al modelo, de la misma manera que la atención en consultorio privado u hospital público o las características o temas del paciente. Por lo tanto, más allá del modelo, es importante hablar del “estilo terapéutico”. Dentro de las limitaciones personales que modifican al modelo se hallan ciertas características de pacientes y temáticas que perturban al terapeuta en su libre ejercicio. El objetivo de este trabajo es explorar cuáles son los temas (historias y problemas) y las características (rasgos de personalidad y patología) de los pacientes que generan rechazo a los psicoterapeutas (psicólogos y psiquiatras) argentinos, tomando en cuenta otras variables como años de ejercicio profesional, zona de atención, género y modelo terapéutico. Se realizó un estudio transversal, descriptivo-correlacional, mediante encuestas. Los temas que generaron mayor rechazo absoluto en los terapeutas fueron los torturadores, abusadores, asesinos y criminales.

Palabras clave: psicoterapia, pacientes, estilo terapéutico, género, ejercicio profesional

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Introduction

Psychotherapy can be defined as the relation between two or more people in which one of them consult another one-more suitable in dealing with human´s problems - in order to solve their own.

When someone starts a therapeutic process, instantaneously activates a categorical scheme about what is supposed to be the role of the psychologist or psychiatrist: expectations about the model, the scientific rigor, the professionalism, etc. On the other hand, unlike other professions, therapeutic work inevitably passes through subjective perception. The personality of the therapist acts as an intermediate filter in the way of constructing the reality of each patient, and at the same time conditions a particular way of intervening on a problem.

Fernández Álvarez (1996) points out that it is possible to conceive the "style" of the therapist as the ways of being constant, habitual and unique of each therapist. This therapeutic style will include factors such as ideas, beliefs, life situation, life experience, interpersonal relationships in general, socioeconomic position, social environment, affective style, religion, emotional and cognitive processes, its history, world view, flexibility, etc. Also, there are contextual factors that shape their styles, such as the place of attention (whether public or private), the sociocultural context, the social class with which they work, the history of the patient and their personal and relational characteristics, the problems they treat and the forms of therapy - individual, group, family, couple- (Ceberio & Linares, 2005).

For the effectiveness of psychotherapy, it is considered that the therapist must have an attitude based on respect, acceptance, empathy, capacity and enough training for stimulating changes. It implies making deliberate efforts for not criticize, judge, or react emotionally in the face of provocations, while creating a good framework and a positive atmosphere. This attitude of respect and therapist abilities are related to the possibilities that he/she has for satisfaction and personal security and not only for an ethical criterion in the attention (Pope & Vasquez, 2016; Rosembaum, 1985; Verdier, 1997). However, the therapist, like every human being does not achieve the aspiration to that idea of suitability, since his own beliefs and categorizations come into play. That can lead him to reject a patient with a particular personality or problematic. Beyond their training and their specific therapeutic model, these variables of style take part in the stage.

For this reason, there are no therapists who develop models in their purest essence because not even the creators of a model acted in an orthodox manner, they ultimately constituted it and implemented it according to their style (Ceberio & Linares 2005).

For these reasons, the elaboration of a protocol that identifies those relationships and challenging topics for the therapists, make it possible to know which are the limitations with which a therapist can be found at the time of intervening. Although it is understood that they are general disturbing elements, each particular therapeutic situation should be analysed, since if there is a personal relationship, the link psychotherapy relationship. This places on the ideal platform the impossibility for the therapist to work

dissociated since not only is operated with the therapeutic model but with its conceptual map that depends on its cognitive structure.

The "instrumental dissociation" (Bleger, 1964) shows that the professionals have rigidly interpreted what the author tried to transmit in his "Techniques of framing" proposed in the Method of institutional work. However, these rigidities that are established from models or concepts are frequent in the field of psychotherapy - although also, the same phenomenon occurs in other fields of scientific endeavour.

In general, when talking about "dissociation" in psychotherapy, it is assumed that the professional manages to distance himself in such a way that he becomes immutable to the patient's reactions and interventions. As a technique, then, instrumental dissociation is related to "objectivity." This interpretation understands an observer outside the field of observation. This is a utopia. We could affirm that objectivity and subjectivity are not opposites, but that objectivity is subordinated to subjectivity: we are always absolutely subjective, but there are different degrees of objectivity within subjectivity. Epistemologically, it is not possible to dissociate in the sense of leaving oneself and observing what happens in the therapeutic interplay, because this distancing is a fallacy (Kerman, 2014).

In short, each of us generate a systemic dynamic, and our cognition attributes meanings, which is why it is only a map that we can obtain from what happens: the map of the relationship. Some concepts are clear to explain the general endorsement of the research:

a- Reciprocal transfers

So, involved in the place of an observer, Psychoanalysis raised the concept of "countertransference," based on the feelings, fantasies, identifying figures, etc., that emerged in the psychoanalyst about his patient (Baranger, 1982; Freud, 2001). This as an opposer of the concept of transference: "the process by which the unconscious desires are updated on certain objects, within a certain type of relationship established between them and, of a special mode, within the analytic relationship "(Laplanche & Pontalis, 1985, p.439).

Meanwhile countertransference as its relational counterpart is defined as "the set of unconscious reactions of the analyst to the person of the analysand, especially to the transference of this. [...] Freud sees the result of the patient influence on the unconscious feelings of the doctor and stresses that no analyst goes beyond what his complexes and internal resistances allow, which has as a corollary the need of the analyst of to submit to a personal analysis "(Laplanche & Pontalis, 1985, p.84).

It is questionable who begins the transaction of feelings or thoughts to whom. From a cybernetic perspective, it is impossible to delineate precisely what things of the other stimulates the projection of what. This degree of behavioural reciprocal influence acts synergistically in the therapeutic context. It relies both on nonverbal attitudes - gestures, postures, attitudes, etc. - as well as the stories that are brought to the consultation and could influence the sensibilities of the professional. However, the stories that lead the patient to consult are in some way "provoked" by the interaction of the therapeutic relationship. The stories told by the patient are driven by the stories that the professional returns based on the stories told by the patient, composing an endless game.

From any of these edges, it seems difficult to speak about stimulus (transfer) and reaction (countertransference). We could be trapped and immobile looking to decipher the primacy. In this sense, Pichon Riviere (1995), prefers to use the term "reciprocal transfers." For the author, this would have been inappropriately called countertransference or set of unconscious reactions of the operator to the group, the task and the transferential processes that are fulfilled in it. All this will feed into the operator the fantasy capacity to establish hypotheses about the implicit event of the

group, resulting in a valuable element in the therapeutic work.

It is understood, then, that such an exchange of adjudications should not be summarized only to the people, but to the context where the psychotherapy is developed. Consultation space, the person of the patient and the therapist, type of problem, stories told, gestures, actions and interactions, evolutionary cycles, are some of the elements that make up the transferential whole. The fact that transfers exceed the perimeter of psychotherapy is already referred to by Bleger (1964): "*Transference and countertransference are phenomena that appear in every interpersonal relationship, and for that reason, they also occur in the therapeutic interview. The difference is that lately they must be used as technical instruments of observation and comprehension "*(p.37).

b- Resonances

Systemic model brings up the concept of "Resonance" (Elkaim, 1992) to talk about feelings, internal voices, experiences, which are detonated in the therapist from the subjects, interactions and the person of the patient (Urban, 2017). Voices that refer to their history, in crossings of isomorphisms, in identifications with parental figures, in reinstitution of dynamics from other contexts in other times, other places, etc. So here again there is the impossibility of dissociation. These resonances are not only in the contents of the subjects that the patients bring. They also appear in manners and styles of interactions, dynamics, family games, which mobilize a therapist during and after a session. Situations of triangulation or disqualification can lead the therapist to confront feelings of abandonment, witnessing and participate in a coalition post of a rivalry or a joint alliance in the face of a severe crisis (Ceberio, Medina, & Linares, 2007).

Also, specific characteristics of personality, figures that are identified with significant characters of the therapist's history, remove old feelings or activate Achilles heels, undermining self-esteem, cutting off creativity, stiffening the muscles as the true expression of the tension generated by the interaction (Cesio, 1963).

At the time of an intervention, contents, interactions or person of the patient, have an impact in the cognition of the professional with little discrimination of which of the three points is the effector of isomorphism: if the story told is the one that produces particular sensations and reactions in the professional, or the gesture or the analogical language that goes with it or the game that develops, etc. It is possible, also that the therapist is not aware of such isomorphism. For this reason, the importance of personal therapy should be emphasized, as part of training and fundamentally supervision.

c-The work of the therapist's self.

Beyond theoretical training and clinical practice, work with the therapist's self is one of the most substantial resources to generate responsible and authentic professionals when intervening. Personal therapy, on the other hand, as a space for reflection, allows us to review the archives of the past and the here and now in the attempt to redefine versions of the story told. The history that takes effect every day in the daily life of the office, since the session can be conceived as a context where different narrations of the patient happen, some of which will fit with the versions of the professional's history (Keeney, 1983, 1990 Von Glasersfeld, 1988).

However, we have pointed out another essential point: supervision. The issue that does not only concern professional training but also responds to ethics and responsibility in psychotherapy, a topic that was developed exhaustively by William Doherty and that Mara Selvini (1989) highlights in its developments.

The supervision, in the hands of a professional accredited by his training and experience, provides the therapist a space where he can present both the clinical strategies of his cases and his redesign, as well as his current and historical cognitive and emotional repercussions. A place where their

doubts and insecurities echo, their hypotheses, feelings, their reflections, and defences, etc., in the search for containment and guidance in therapeutic work. A supervisor is a reference. A teacher who encourages creativity, which as such teaches introducing germinal ideas, which supports academically and affectively. The supervision, then, is the space where the therapist can take his resonances, go to his history, appeal to his most sensitive corners. However, also the resonances can be translated as therapeutic interventions. The emotion that is detonated in the relationship with patients, both anger, fear, blockage, happiness, etc., are feelings that, when evaluated by the professional, can have their specific weight if they are explicit.

In short, resonances, countertransference or transfers, reciprocal transfers, beyond the label with which they wish to be called and of the model that sustains it theoretically, shows the feedback of human relations. In any of its versions and forms, the conclusion is that such effects and causes, in a relationship as human as therapeutics, cause a series of complexities that try to unravel complications. Therapist and patient, in a recursive whole, try within the subjectivity of the relationship to reach levels of greater objectification of the observable.

Some previous research

Therefore, this research investigates the rejection by therapists towards a particular type of patients suffering from pathology or with a characteristic of action or issues to solve that cause disturbance in the care. There are no investigations or, instead, they do not focus the focus of study on this thematic axis, but only partially. Some of them are referred to work with the terminally ill (Pereira Tercero, 2010, Barreto & Bayés, 1990); specific disorders such as schizophrenia (Arriba-Rossetto, Senra-Rivera, & Seoane-Pesqueira, 2008); homosexuality (Martínez Gómez, Moral de la Rubia, & Valle de la O, 2013); patients with AIDS (Belisario, 1996), among others.

However, we have not found previous research in cases where therapists openly reject rejection as, i.e., sexual abusers, criminals, and very violent killers. We can only make inferences for the initial casuistry that we developed for the construction of the test protocol (100 therapists). It is remarkable that these disorders have not been investigated, although it is not strange since what abounds are the explorations in pathologies but not in therapists, and this could be thought of as a symptom of professional omnipotence.

Method

The main aims have been to explore issues such as history, problems, and observe what those characteristics of patients - personality traits, pathologies – can generate rejection in the therapist. Regarding the specific objectives, we sought to explore the relationship between years of professional practice and rejection levels; the models of psychotherapy and the levels of rejection. As well as describing the existence of a profile of patients rejected by the therapist regardless of their model and years of professional practice; and the incidence of gender -female or masculine- when rejecting a patient.

The initial hypothesis to confirm or refute in the development of this research was if specific personality characteristics of patients are frequently rejected by the therapist beyond the therapeutic model, the age and the time of professional practice. Specific characteristics as torturers, abusers, murderers, elderly, dying or terminally ill patients.

To describe the issues that most reject generate in mental health professionals, a transversal and descriptive-correlational study was carried out through surveys (León & Montero, 2002). For the statistical analysis of the data, IBM SPSS 20.0 for Windows was used. The total score of the scale, as well as its reagents, were worked as variables with a level of interval measurement, reason for which the Pearson's r test was used to analyse associations between these and other variables with interval (e.g., age) or ordinal (e.g., years of receipt) level. For the comparisons of two groups about their scores on variables with interval or ordinal level, Student's t-test was

used (e.g., comparison of men and women in the score of a reagent). Comparisons between three or more groups were made using the analysis of variance (ANOVA), given the large sample size. The homogeneity of variances was tested through the Levene test and in all cases, it was found that there were no significant differences between groups. Therefore, differences were analysed through analysis of variance models.

A questionnaire included a printed and online version, to encourage the participation of professionals from all over the country. For the collection of surveys, a "snowball" effect was sought, as a multiplier, as well as the participation of professionals belonging to different institutions.

Educational and therapeutic throughout the country. Before beginning to answer, the participants were notified about the anonymous and voluntary nature of their participation in the study, a general idea regarding the objectives and their academic purposes, and the duration of the survey - estimated in 5 minutes. The inclusion criterion for the sample was that the participants had qualifications for undergraduate degrees in psychology, psychologists or psychiatrists.

The data collection took place during November 2015 and June 2016. A structured instrument was prepared, consisting of a list of questions previously agreed upon with approximately 100 therapists from the staff of the Argentine Systemic School and other institutions. The response scale is Likert type that advances from 1: Null rejection (it does not bother me to work with these cases); 2: Scarce rejection; 3: Moderate rejection (work, but uncomfortably); Intense rejection; a 5: Complete rejection (I avoid working with these patients).

This study had a non-probabilistic incidental sample of 322 participants, between 22 and 84 years old (M = 39.86, SD = 11.19), of which 255 were women and 67 men, representing 79.2% and 20.8% of the total the sample respectively. 34.7% of the participants lived in the Autonomous City of Buenos Aires, while 14.1% lived in Greater Buenos Aires, 51.2% in the interior of the country. About the specialty, 94.4% of the sample was constituted by professional psychologists and the remaining percentage by psychiatrists. Regarding the number of years of professional practice, the sample counted with 55.5% of professionals with less than that ten years graduated; 26.8% between 10 and 20 years graduated; 9.7% between 20 and 30 years; and 8.1% with more than 30 years of practice. 38.3% of the therapists had a systemic approach, while 23.8% with a psychoanalytic approach, 19% cognitive-behavioural, 9.3% eclectic, and the remaining 9.6% belonged to other therapeutic models (e.g., gestalt, integrative, etc.).

72% of the participants completed the instrument in its online version and 28% in the printed version.

Results

The subjects that generated absolute rejection in the therapists were the torturers, abusers, murderers, and criminals. On the other hand, the subjects that presented the least rejection were the people in the process of mourning, obsessive, phobic and panic, homosexuals and bisexuals (see table 1).

Table 1
General identification of topics of greatest rejection means, standard deviations and percentages of absolute rejection response.

Subject	M	DE	% complete rejection
1. Torturers	4.24	1.15	62.4
2. Tortured	1.92	1.16	5.3
3. Abusers	4.33	1.01	62.1
4. Abused	1.68	1.03	2.5
5. Addicts	2.30	1.25	6.5
6. Depressive, melancholic	1.90	1.08	3.1
7.Terminal and dying patients	2.38	1.37	12.2
8. Persons in process of grieving	1.32	0.63	0
9. Elderly	1.75	1.06	2.8
10. Physically Disabled	1.65	1.08	3.8
11. Mental Disabled	2.37	1.35	9.9
12. Psychotic	2.55	1.42	14.4
13.Homosexual and bisexual	1.22	0.63	0.9
14.People with alternative sexual practices	1.61	1.02	2.2
15. Narcissistic and pedantic	2.55	1.26	10.3
16.Victims, guilty and complainants	2.09	1.11	2.8
17.Violent and aggressive	3.19	1.33	20.9
18. Manipulators	2.88	1.22	11.3
19.Murderers and criminals	4.18	1.22	62.3
20. Rigid	2.07	1.09	2.8
21. Xenophobes	2.77	1.31	14.5
22. Lack of hygiene	2.84	1.26	13.1
23.Phobic and panicky	1.36	0.70	0.3
24.Obsessive	1.38	0.71	0.3
25.People with eating disorders	1.67	1.04	2.8

Due to the insufficient number of psychiatric professionals (n = 18), no comparisons were made between these and the psychologists, and they were analysed. As is logical, the age of the therapists and the number of years of professional practice were strongly correlated ($r = .75$, $p < .001$). None of these variables was related to the overall rejection score of the scale ($p > .59$).

Then, the analysis of variance (ANOVA) (see table 2) of a factor was performed, where only patients were observed in which statistically significant differences were observed in rejection levels by different psychotherapists, according to the therapeutic model with which work - systemic, cognitive-behavioural, psychoanalytic, eclectic, others.

Table 2
Rejection according to the therapeutic model

		Sum of squares	Gl	Half quadratic	F	Sig.
E5_Addicts	Inter-group	26.389	4	6.597	4.444	.002
	Intra-group	454.273	306	1.485		
	Total	480.662	310			
E6_Depressive Melancholic	Inter-group	15.607	4	3.902	3.405	.010
	Intra-group	350.676	306	1.146		
	Total	366.283	310			
Terminal Diseases	Inter-group	28.548	4	7.137	3.875	.004
	Intra-group	563.594	306	1.842		
	Total	592.141	310			
Old age	Inter-group	21.676	4	5.419	5.203	.000
	Intra-group	317.679	305	1.042		
	Total	339.355	309			
Mental disability	Inter-group	21.637	4	5.409	2.995	.019
	Intra-group	525.485	291	1.806		
	Total	547.122	295			
Psychotics	Inter-group	66.078	4	16.520	9.034	.000
	Intra-group	557.715	305	1.829		
	Total	623.794	309			
Homosexual and bisexual	Inter-group	6.583	4	1.646	4.216	.002
	Intra-group	119.059	305	.390		
	Total	125.642	309			
Narcissist and pedant	Inter-group	17.954	4	4.489	2.863	.024
	Intra-group	478.123	305	1.568		
	Total	496.077	309			
Rigid	Inter-group	16.593	4	4.148	3.641	.006
	Intra-group	347.475	305	1.139		
	Total	364.068	309			
Lack of personal hygiene	Inter-group	17.937	4	4.484	2.861	.024
	Intra-group	478.001	305	1.567		
	Total	495.939	309			

Although significant differences were observed in all of them, when Post-Hoc contrast was carried out, which implies a more detailed analysis, it was observed that only in some of the cases, true differences and groupings take place. As an example, we take the case of addicted patients (see table 3), which is then extrapolated to all cases, where, in principle, statistically significant differences were observed.

Table 3
Rejection of addicted patients according to the therapeutic model

Therapeutic Model	N	Subset for alpha = 0.05		
		1	2	3
Other	30	1.90		
Psychoanalysis	74	2.01	2.01	
Systemic Therapy	119	2.23	2.23	2.23
Eclectic	29		2.59	2.59
Behavioural – cognitive	59			2.76

However, it should be noted that although there are differences in the levels of rejection of addicted patients among some psychotherapists and others, the levels are still low. That is to say that, as shown in Table 3, in cognitive behavioural therapists despite significant differences in the levels of rejection towards addicted patients with respect to other psychotherapists, having an average of 2.76 are still between a poor rejection and a moderate rejection. This same pattern is observed in most of the tables -of the different subjects of rejection-, not observing any average above 3 except in psychotic patients.

Table 4 shows the results of the correlations between the years of practice of the profession and the issues of rejection.

Table 4
Correlations between years of professional practice and issues of rejection

Issues	Years of professional practice
Torturers	.072
Tortured	-.019
Abusers	-.057
Abused	-.093
Addicts	.081
Depressive -Melancholic	-.162**
Terminal Diseases	-.136*
Grieving Process	-.094
Old age	.005
Physical Disability	.001
Mental Disability	.026
Psychotics	-.007
Homosexuals and bisexuals	.009
People with alternative sexual practices	.099
Narcissistic and pedant	.031
Victims, guilty and complainers	-.024
Violent and aggressive people	.045
Manipulative people	.112*
Murderers and criminals	.114*
Rigid	.032
Xenophobic	.114*
Unclean people	.138*
Phobic and panicky	.018
Obsessive	.027
People with TCA	.036

Only some significant correlations -both positive and negative- between the years of professional practice and rejection levels were observed. If pay attention to the second column, it is inferred, for example, that the greater the number of years of professional

practice, the lower the rejection of melancholic depressed patients (-162) and of people with terminal illnesses (-.136). Meanwhile, regarding murderers and criminals, xenophobes, unhygienic and manipulative people, the greater the number of years of profession, the higher the level of rejection by professionals. However, and as in most of the results presented, it is important to emphasize that, in no case, the rejection level is greater than "scarce". It is highlighted, according to the foregoing, that although there are significant correlations, the results did not yield a moderate, intense or complete rejection under any factor; but null or scarce. It should also be considered that the values of the correlations are weak.

The comparison of the therapists according to their sex showed that both groups did not differ significantly in the degree of global rejection ($p = .09$). However, some statistically significant differences were observed regarding the subjects.

The group of women therapists showed greater rejection towards the torturers ($t [318] = -2.87$, $p = .004$), tortured ($t [319] = -2.96$, $p = .003$), abusers ($t [320] = - 4.44$, $p <.001$), depressive and melancholic ($t [318] = -2.56$, $p = .011$), violent and aggressive people ($t [107.800] = -2.12$, $p = .036$) and xenophobes ($t [105.95] = -2.40$, $p = .018$).

Discussion

Taking into account the data obtained in relation to the percentages of the subjects rejected in an absolute way, it should be noted that the "torturers", "murderers" and "criminals", and "abusers" are the ones that achieve the greatest value (62.4%, 62.3%, 62.1% respectively). It is expected to arrive at these results because, torturers, murderers and criminals are three universal pillars of rejection for most of the humanity, because life is considered the most precious gift and in these cases these patients attempt against it or against integrity psychophysics of the person. With regard to the "torturers", we could infer that the reason for which it receives a special resonance in our therapists is due to the lived, suffered or heard history that crossed our country in the 70s of the hand of the military dictatorship that systematically violated the human rights of citizens, as in much of Latin America. According to the semantics granted, it will represent a traumatic memory.

The data obtained in relation to the least rejected and with a result of less than 1%, were the "obsessive" (0.3%), "phobic and panicky" (0.3%), "homosexual and bisexual" (0.9%), and "People in the process of grieving" (0%). Patients with obsessive-compulsive, phobic and panic disorders are very frequent in the current clinic, and they are increasing. In addition, they make up the large diagnostic pictures that prevail today. They are highly studied disorders in recent years, resulting in effective interventions for these problems. Then, both the incidence and the frequency in the consultation, as well as the wide and varied offer of therapeutic resources, would influence so that this type of patients and topics do not generate disturbances in the therapists. In relation to the lower rejection of homosexuals and bisexuals, it is possible that this partially demonstrates the develop made by the therapists for following the change of the Argentine society in relation to respect for personal sexual choices, respect and acceptance of sexual diversity. This acceptance gained strength after the enactment of the Equal Marriage Law of 2010 in our country (Law 26,618). In addition to that the ideology of gender is increasingly immersed in acceptable social discourses. That is, sexual and gender diversity not only has greater recognition and social legitimacy, but also, homophobic or discriminatory responses have a social sanction, so that it is possible, in addition, to be registering a more marked effect than in other reagents, regarding social desirability. In addition, today, professionals see these issues reflected in the consultations of homo-parental families, which are part of the new family structures and therefore, new therapeutic challenges. At present, we find ourselves with the design of family structures different from the traditional ones, which confront us with our old family designs that include parents from the decade of

1930/1940/1950 and the consequent values and beliefs of an era. This clash of cultures subjects the therapist to revise their own conceptual schemes in order to carry out more effective interventions (Ceberio, 2013a).

It is interesting to note that nobody absolutely rejected people in the process of grieving. It is the only 0 percentage of the entire sample. Possibly this result is because it is a subject that crosses us and transcends all of us in one way or another at some point in life, enabling us to develop great empathy towards the suffering patient. In the rest of the items studied, the level of rejection is between 2% and 15%, except for the "aggressive and violent" that reach 20.9%. In the sample it is striking that there are no intermediate values between the values of the most rejected (62%) and the least rejected that reach 7%. We could mean that 20.9% of rejection of aggressive and violent, that although it is not a very relevant percentage is the one that follows the most rejected. Violence is not a pleasant emotional state, but it is not only the climate of the session that disturbs and alters in crescendo but the risk that it implies for the therapist. In fact, it was women who mainly rejected the situation of the encounter with these patients. Other values ranging from 10 to 15%, as "narcissistic and pedantic" (10.3%) and "manipulative" (11.3%) and xenophobic (14.5%) may be due to the tendency that they are patients of a disqualifying attitude towards their environment and towards the therapists themselves. Regarding the values of "psychotic" (14.4%), working with this category of patients is specific and often debilitating, however the values of complete rejection were not as high as expected. Finally, the "terminal and dying patients" (12.2%) is not a relevant number either, but working with people knowing their dead line is not a specialty much sought after by therapists. It is interesting to note that terminal patients and old ages are the least wanted specialties. It is known that the specialty in old age and the treatment of the elderly is not a preferred choice by therapists compared to couples, adults or adolescents and children. The elder reflects what awaits the therapist over time and no one likes to project at that stage (Ceberio, 2013b). For this reason, working with older adults - gerontology - is not the first choice. However, the rejection percentages were not significant. Finally, the "lacking in hygiene" (13.1%) although they are not significant, in the average of complete rejection they have an outstanding value. This shows that rejection can occur neither by subject, nor by personality trait, but by a random factor to such signs: patient cleanliness.

When the relationship between psychotherapy models and rejection levels was investigated, it was observed that those professionals with the lowest rejection percentage were those who adhered to less unspecified models (i.e., "Others"). In addition, those who rejected the most were those who adhered to a model of cognitive behavioural therapy. These therapists tend to have more structured approaches specific to certain reasons for consultation and pathologies, so it is possible that they have a pre-established and less permeable tendency, regarding the scope of the type of therapy they can develop. In any case, although statistically significant differences were observed considering the response scale used in the questionnaire, the rejection remained small or moderate. In relation to the level of rejection and the age of the therapist, the most rejected issues by older professionals are murderers and criminals, manipulators, xenophobes and lacking in hygiene.

Through the data it is observed that the greater the year of professional practice, the lower the rejection of depressed or melancholic patients and terminal illnesses, which could be correlated with the life cycle of the professional, taking into account that adulthood and old age They encourage reflections on the years lived and anguish in pursuit of one's own finitude.

Although the results obtained do not reveal significant differences regarding the sex of the therapist, it is observed that women therapists reject more strongly those groups that are characterized by violence as "torturers, tortured, violent, aggressive, abusers", and those that attack the most vulnerable

minorities such as the "xenophobes". This could be explained by the greater feminine constitutional physical weakness, the risk that implies, that in front of these pathological groups of power, position the professional in a place of greater vulnerability, being able to awaken fear in front of these therapeutic links, thus hindering the treatment. This would be reconfirmed by the historical gender violence that affects all women universally.

All these data obtained in the present investigation, both by rejected patients in general -in subjects and personality-, in distinction of gender, years of exercise, or models of psychotherapy, shows that therapists react to certain patients that disturb the free attention and that it is not possible to act effectively. Observe a therapist involved in the field of interactions of the session that, within the subjectivity of the therapeutic relational system, is objective and this will depend on the semantic attribution with which the case is constructed.

Authors' participation:
a) Conception and design of the work; b) Data acquisition; c) Analysis and interpretation of data; d) Writing of the manuscript; e) Critical review of the manuscript.
M.R.C. has contributed in a,b,c,d, e; J.A. in a,b,c,d; M.D.V. in a,b,c, e; R.V in a, b, c, d.

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