WHEN CLIENTS DON'T COME BACK: HOW NOVICE PSYCHOTHERAPISTS EXPERIENCE PREMATURE TERMINATION OF THERAPY

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Contents

Abstract

Research shows that premature termination of therapy is a common and problematic occurrence in the mental health field, with at least 20% of clients leave therapy prematurely (Swift & Greenberg, 2012), before achieving their treatment goals (Swift et al., 2012). While clients continue to need mental services (Swift et al., 2012; Westmacott et al., 2010), therapists can experience burnout and a sense of failure (Klein et al., 2003; Pekarik, 1985a). A study by Piselli et al. (2011) explored the experiences of seasoned psychologists after clients terminated therapy prematurely, but to date, no in-depth qualitative study has been conducted to learn about how novice therapists experience premature termination of therapy. Client dropout rates and feelings of incompetence are more prevalent among novice therapists than their seasoned counterparts (Swift & Greenberg, 2012; Thériault & Gazzola, 2010). This thesis focuses on novice psychotherapists' feelings, cognitions and behaviours after clients dropped out without any explanation, which is similar to ghosting in dating relationships (Pancani et al., 2022). Qualitative data was gathered from interviews with seven novice psychotherapists in Ontario, Canada. Structured Thematic Analysis Braun & Clarke, 2006; Clarke & Braun, 2017) was used, and the following main themes were identified: Therapist responses to being ghosted, how therapists processed being ghosted, nature of therapy termination, aspects of therapy delivery, elements of novice therapist development. The results highlight how novice therapists benefit from supervision and the normalization of premature termination of therapy.

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Tables and Figures

When Clients Don't Come Back: How Novice Psychotherapists Experience Premature Termination of Therapy

Premature termination of therapy is a common problem affecting clients and therapists. The most recent meta-analysis of 669 empirical studies published in the English language revealed that 20% of clients prematurely terminate therapy (Swift & Greenberg, 2012). There is a variety of definitions, but to provide a basic understanding, premature termination of therapy can be thought of as a client unilaterally deciding to end the therapeutic relationship before the treatment goals are achieved (Swift et al., 2012). Clients' reasons for premature termination include feeling satisfied with their progress in therapy, a change in circumstances such as their financial situation, and dissatisfaction with the therapist or therapy (Westmacott et al., 2010). Hindering events in therapy, such as the therapist falling asleep in a session, can also indirectly contribute to premature termination of therapy (Burton & Thériault, 2020).

Research shows that premature termination of therapy is problematic for clients, mental health organizations, and therapists because it is economically and psychologically costly. Clients and therapists spend time on treatment that is often terminated before therapeutic gains have been made, leading to the clients needing more services later (Swift et al., 2012; Westmacott et al., 2010). When clients end therapy prematurely, their therapists can experience a sense of failure, burnout and decreased job satisfaction, which can in turn lead to high job turnover (Klein et al., 2003; Pekarik, 1985a). Feelings of incompetence are already a common occurrence in therapists (Thériault & Gazzola, 2010); the high prevalence of premature termination could add to the negative experiences of therapists, particularly novice therapists, who typically struggle with insecurity during the early phases of career development and experience great fluctuations in professional confidence (Hogan, 1964; Loganbill et al., 1982; McNeill & Stoltenberg, 2016; Owen & Lindley, 2011; Rønnestad & Skovholt, 2012; Skovholt & Rønnestad, 1992, 2003; Skovholt & Trotter-Mathison, 2016).

Indirectly, research shows the negative effects of premature termination on therapists, but only one study by Piselli et al. (2011) directly asked therapists how they experience premature termination and what the impact is from their perspective. Piselli et al. used the consensual qualitative research (CQR) method (Hill et al., 2005) to gather and analyze data from experienced board-certified psychologists. Piselli et al. examined the psychologists' reflections on cases of premature termination of therapy, including warning signs, causes, prevention efforts, personal

impact, and professional impact. Piselli et al. (2011) found that around half of the therapists in their study reported they had not foreseen the premature termination by clients, and the other half of therapists reported noticing warning signs, such as absences or the client expressing unwillingness to engage and declaring he or she could leave therapy if they feel it is not working. The therapists reported that clients did not communicate a reason for premature termination and that they attempted to contact the clients to offer further support. Premature termination was typically attributed to the clients' psychopathology. Regarding personal impact, the therapists reported feeling anger, frustration, loss, sadness, guilt, regret, relief, failure, shame, confusion, and surprise. There were some results that possibly conflict, in which therapists reported the termination did not affect their sense of professional competence, yet therapists reported experiencing a lasting sense of uncertainty and reduced professional confidence. However, since the results of the Piselli et al. were reported if the phenomenon occurred in six or more cases out of the total eleven cases, it is impossible to tell whether such seemingly conflicting results come from the same or different therapists in the sample. Reportedly "a few therapists" felt the emotional impact of premature termination of therapy "months, and even years, later" (Piselli et al., 2011, p. 410).

To gain a deeper understanding of how therapists process the occurrence of clients' unilateral termination, the present qualitative study was designed to gather data on therapists' experiences of premature termination, including their emotions, cognitions and behaviours. Unlike the study by Piselli et al. (2011), the study focused on the experiences of novice psychotherapists and data was analyzed using Structured Thematic Analysis (Braun & Clarke, 2006; Clarke & Braun, 2017).

The study utilized a sample of seven novice psychotherapists, defined as having less than five years' experience (Rønnestad & Skovholt, 2012), because feelings of incompetence are more prevalent among novice therapists (Thériault & Gazzola, 2010). Premature termination of therapy may impact the experiences of novice therapists more than seasoned therapists if it adds to the already high prevalence of feelings of incompetence. Novice therapists have a higher client dropout rate than seasoned therapists (Swift & Greenberg, 2012), making premature termination a particularly common experience among novice psychotherapists. Premature termination of therapy is part of the wide range of phenomena therapists encounter, such as secondary trauma, but it is less talked about. It is important to raise awareness of what it is like for novice

psychotherapists to have clients quit without notice, because "it is ignorance about the challenges you will face that most contributes to the feeling of being ambushed when these challenges do inevitably occur" (Kottler, 2022, p. 102). Additionally, according to Rønnestad and Skovholt (2012), optimal professional development includes awareness of the intricacies of working as a therapist, which would include premature termination of therapy.

Literature Review

The following literature review is selective rather than comprehensive. The purpose of a selective literature review is to locate the proposed study in the existing body of research. The current study lies at the junction of the topics of premature termination of therapy, occupational hazards and the impact of premature termination on therapists, therapist self-care and therapist development. The literature review outlines the problematic variability in the definition of premature termination of therapy, evidence for the specific challenges faced by novice therapists in addition to the common occupational hazards of psychotherapy, how self-care is conceptualized in the occupation, the significance of researching premature termination, and the need for a new study.

Defining Premature Termination of Therapy

Premature termination of therapy has been named and defined in various ways in the mental health literature. Researchers have used the terms attrition, unilateral termination, dropout, and premature termination to describe the phenomenon of clients leaving therapy (Bados et al., 2007; Swift et al., 2012). Researchers agree that attempting to use one definition of termination of therapy is impractical because there are many different processes involved in the various types of therapy termination (Kokotovic & Tracey, 1987; Westmacott & Hunsley, 2017). The distinct processes behind when and why clients decide to terminate therapy mean that not all instances of termination can be considered premature or dropping out of therapy. For example, a client terminating after an intake session because they are unready to engage in therapy is a very different situation than a client who terminates after attending multiple sessions because they experience symptom improvement and would like to save money by ending therapy at that point.

For the current study, premature termination of therapy is defined as a client unilaterally ending the therapeutic relationship before their treatment goals are achieved (Swift et al., 2012). According to Pekarik (1985b), therapy duration, or number of sessions, can unfortunately group early completers and dropouts together. Pekarik states the key element in researching therapy

dropout is the client's unilateral decision to end therapy, without the therapist's agreement. The definition reflects the harmful and problematic nature of premature termination instead of lumping it together with clients finishing therapy early due to improvement of symptoms or changing circumstances such as a client's inability to pay for further sessions (Westmacott et al., 2010). The definition also eliminates the problem of conceptualizing premature termination as ending therapy prior to completing a prescribed number of sessions, which again, could be related to client improvement or a change in the client's financial situation.

In this study, premature termination of therapy is akin to the contemporary dating term, "ghosting," in which there is some interaction between parties and then one party ceases all contact without offering any explanation (Pancani et al., 2022). As such, premature termination of therapy means the client has attended multiple sessions with the therapist and subsequently stopped therapy unilaterally, with no explanation given. Such a conceptualization excludes attrition explained by improvement in mental health, inability to afford therapy, and situations in which the therapist terminates the relationship with the client. To summarize, the study focused on the unexplained and unexpected premature termination of therapy by clients who have been engaged. Previous literature mainly focuses on the reasons clients terminate therapy and the impact premature termination has on the client rather than the therapist. The author gathered data to learn more about therapists' experiences of premature termination.

Therapist Development

Several classic models of career development are relevant to the development of therapists. The models are succinctly outlined by Rønnestad and Skovholt (2012) in their book on practitioner development, in which they also present their own model of therapist development. Most of the developmental models in the existing literature include supervision techniques that correspond with the different stages of therapist growth, but since supervision techniques are not relevant to the current study, the following overview of developmental models focuses on the characteristics of therapist development and excludes supervision techniques.

Models of Therapist Development

Super (1956) asserts that an individual's development is a process rather than a series of events in his classic work on career development. Super's career development theory of the professional self has been incorporated into models of therapist development although it is not specific to therapists. According to Super (1956), the process of development involves interaction

between individual factors and environmental or cultural factors. Super describes the individual factors as needs, interests, aptitudes and values, while environmental factors are economic resources, opportunities available, cultural and social demands. Much later, Rønnestad and Skovholt (2012) incorporated the concept of a professional self in their model of practitioner development, which states that therapists' go from having a "fragile and incomplete practitioner-self to a solid and complete practitioner-self" (p. 15). The idea that a therapist's self-concept changes and develops over the career span is a common theme throughout the developmental models.

Hogan's (1964) model of psychotherapist development consists of four levels, which can combine and be repeated over the lifespan. During Level 1 therapists are dependent on supervisors, reliant on one method of therapy, insecure, lacking insight yet highly motivated. Hogan (1964) normalizes the experience of insecurity in beginner therapists by stating they are "insecure, as any apprentice is insecure" (p. 139); indeed, insecurity is a characteristic of novice therapists common across models of therapist development. In Level 2 therapists experience conflicts between being dependent and autonomous, they still struggle with insight, there is ambivalence and fluctuating motivation about working in the profession, moving between high commitment and self-doubt. Therapists in Level 3 are more masterful in the profession, they have higher self-confidence, increased insight, and their motivation towards the work is more stable. In Level 4, therapists can be more intuitive and creative because they are now autonomous, confident, secure, insightful and their motivation for the work is completely stable.

Hill, Charles, and Reed (1981) put forth a model of counselling student development, which has four phases: sympathy, counsellor stance, transition, and integrated personal style. Aspects of the model illustrate novice therapists' anxiety, lack of confidence and general sense of incompetence. Therapists in the first phase are sympathetic towards clients and they tend to focus on giving clients positive feedback and support, much like lay helpers do. In the second phase, termed *counsellor stance,* therapists focus on figuring out their chosen method of therapy to help clients. Typically, novice therapists follow instructions from supervisors and adhere to one method of therapy and apply it across clients. According to Hill et al., when the chosen method does not suit a client, novice therapists "will often feel that he or she is a failure rather than that the model does not fit his or her style" (p. 435). During the transition phase, therapists expand their repertoire of methods, but they have yet to develop a personal style, or way of using

therapeutic methods. The fourth phase involves integrating theory, therapy techniques and personal style as therapists. During this phase, typically after years and much clinical experience, therapists begin to have more self-confidence and they can rely on their own judgment as opposed to that of supervisors.

Hill et al. (1981) advanced empirical research of therapist development by conducting a longitudinal study of doctoral students' counselling skills, using quantitative and qualitative research methods. The quantitative data from the study showed no significant effects of time or anxiety level, although none of the students were considered highly anxious, even at the beginning of the study. When gathering quantitative data, participants' anxiety was measured by analyzing their speech during sessions with clients using Mahl's Non-Ah Speech Disturbance Ratio (1956), whereby a disturbance to word ratio is calculated. Speech disturbances include changing sentences, repeating oneself, stuttering, using incomplete sentences (Hill et al., 1981). The use of filler words such as "ah" and "um," pauses or sighs are not considered to be indications of anxiety in Mahl's measure. Interestingly, according to the qualitative data from the study, all 12 students in the study reported "big decreases in anxiety levels with clients" (p. 432) over time. The qualitative interviews of participants obtained their subjective views of their own anxiety levels, which apparently did not manifest as speech disturbances observable by other people. Qualitative research methods were chosen for the proposed study because they allow for such rich descriptions of subjective experiences.

Loganbill, Hardy, and Delworth (1982) describe novice therapists who are under supervision as going through three main developmental stages comparable to the child development, in that there are individual differences in functioning, and the learning is continuous and cyclical. An individual can repeat the stages over the career span. The first stage is called Stagnation, which is characterized by unawareness of performance or supervisory issues and being stuck or stagnant. During Stage 1, therapists can either have a negative self-concept because they are lacking knowledge and experience, or they can be confident because they do not yet have the insight to perceive problems in their own functioning (Loganbill et al., 1982). In Stage 2, called Confusion, therapists experience greater fluctuations in self-concept, including alternating between feelings of incompetence and feelings of competence. Rather than being stuck, therapists in Stage 2 gain awareness of the self and the complexities of the work, which creates instability, ambivalence and confusion. However, Loganbill et al. (1982) value the

Confusion stage as a process by which therapists become more flexible in their views and behaviours; Stage 2 facilitates change, growth and learning as opposed to stagnation. Stage 3, Integration, is when therapists' self-concepts solidify, and confidence increases. Therapists in the Integration stage are aware of weaknesses in their own functioning but they now accept them and they believe they can become more competent in those weak areas. During Stage 3, therapists' views of themselves, the work, and clients are stable but more flexible than during Stage 1. The Integration stage is considered to be a process of ongoing learning, despite therapists being mature in their development at this point.

Owen and Lindley (2011) propose the Therapists' Cognitive Complexity Model (TCCM); cognitive complexity is related to therapist development, in that therapists' cognitions and metacognitions become more complex with time and experience. The TCCM comprises three phases, which share characteristics with other models of therapist development. In Phase I, therapists acquire knowledge for each new task, and because such knowledge is not yet memorized or internalized, they rely on supervisors and professors for solutions in ambiguous situations. Therapists' metacognitions during Phase I focus on self-monitoring. In Phase II, therapists are better able to focus on how to apply their knowledge appropriately and effectively, and their metacognitions expand to include reflection on how clients respond to therapeutic interventions. Like Loganbill et al. (1982), Owen and Lindley (2011) describe the third phase of development as involving integration. In the TCCM, therapists in Phase III are able to integrate knowledge and personal experience, which helps them draw on internalized knowledge rather than depending on supervisors for guidance. As such, therapists in Phase III have more flexible, intuitive cognitions; metacognitions during Phase III expand further to include the self, specific clients, and commonalities between clients and situations over time (Owen & Lindley, 2011).

McNeill and Stoltenberg (2016) describe an integrative developmental model (IDM), which has been developed over the decades since Stoltenberg's original model of counsellor development in the early 1980s. The IDM consists of the following domains of professional growth for therapists: Self and other awareness, motivation, and autonomy. There are three main levels of development according to the IDM, followed by Level 3i, which indicates integration across the domains of awareness, motivation and autonomy. At Level 1, therapists are highly motivated, dependent on supervisors, cognitively self-focused but lacking self-awareness, and they experience performance anxiety. At Level 2, therapists alternate between low and high

motivation, confidence is low or high, they are less dependent on supervisors, their focus shifts to clients; they experience more empathy but may also overidentify with clients' struggles. At Level 3, therapists' motivation is stable and they have a sense of professional identity, they are mostly autonomous, and cognitively they are highly aware of self and others as well as their own strengths and weaknesses. Therapists at Level 3i have stable motivation and an established professional identity, they are autonomous, and their awareness of self and others is refined according to experience and maturity (McNeill & Stoltenberg, 2016).

Rønnestad and Skovholt (2012) gathered qualitative interview data from large-scale studies on therapist and counsellor development to explain the processes by which therapists move through developmental phases. They identify developmental tasks for each phase of therapist development from novice student to senior professional. Developmental tasks must be met before a therapist progresses to the next phase. The novice professional phase, which Rønnestad and Skovholt define as around two to five years after graduation, involves developmental tasks such as becoming more professionally independent than they were in in the student phases, continuing to explore their professional roles, and overcoming disillusionment. Based on data, Rønnestad and Skovholt suggest that novice therapists experience disillusionment when their work with clients does not go as expected, and loneliness as their increased autonomy means that supervisors, professors and peers recede from their support network. As such, the novice therapist phase seems like a good time to have more peer support, validation and normalization of experiences, and a better idea of what to expect in one's work.

The models of therapist development reviewed above suggest that therapists typically progress and cycle through phases involving variations in confidence, an unstable sense of self that solidifies over time and experience, and reliance on supervisors and external knowledge that shifts toward autonomy with time and experience. The common theme across models is that with time and clinical experience, therapists become confident autonomous professionals. Models of therapist development provide a foundation for understanding the unique issues new therapists encounter, which are further explored in this thesis study.

Struggles of Novice Therapists

According to the research on therapist development, it takes therapists years to become more confident, comfortable, flexible, and experienced. Research by Skovholt and Rønnestad (1992) identified overarching themes of career development, which are: exploration of the

unknown, increasing authenticity, anxiety, hope, reflection, reliance on external expertise, refining professional style and becoming less rigid (Skovholt & Rønnestad, 1992). Over the course of a therapist's career, the increased reliance on internal expertise is accompanied by a decrease in anxiety; the therapist develops more confidence in knowing what to do in various situations and is no longer dependent on supervisors.

There is evidence suggesting that novice therapists experience added stress and anxiety compared to seasoned therapists, and that they often struggle with maintaining the optimal level of attachment to clients (Skovholt & Rønnestad, 1992; Skovholt & Trotter-Mathison, 2016). Interns in the study by Skovholt and Rønnestad (1992) experienced pervasive anxiety, which generally decreases as a therapist develops internal knowledge and expertise, although the level of anxiety can fluctuate over the course of the career (Skovholt & Rønnestad, 1992). Two interns in the research by Skovholt and Rønnestad described their anxiety as changing from "petrified to being comfortable" and being "less afraid of losing patients than in the past" (p. 512). Kottler (2017) states novice therapists experience stress from the ambiguity characteristic of the work because there is often "discrepant feedback…from superiors, colleagues, and books" (p. 82). The lack of straightforward answers is especially stressful for novices because they rely on external expertise for direction; novice therapists have yet to internalize knowledge. Novice therapists might also struggle with the ambiguity and uncertainty surrounding premature termination of therapy, and the experience might add to their overall stress, anxiety, and self-doubt.

Although some stress and anxiety can lead to learning, growth and resilience in therapists (Rønnestad & Skovholt, 2012), high stress can also lead to therapist impairment, which is the inability to care for clients due to personal issues including mental health (Bradley et al., 2013). Impairment in therapists can stem from burnout, anxiety and stress (Roach & Young, 2007). The aforementioned high levels of stress and anxiety in novice therapists could put them at risk for burnout and therapist impairment. Paradoxically, impairment and burnout can lead to ruptures in the therapeutic alliance and likely premature termination of therapy due to unsatisfactory therapy (Ogrodniczuk et al., 2005). Premature termination of therapy ends the attachment in the therapeutic relationship at a less than optimal juncture, without closure. As a result, the therapist can feel like they failed the client in some way, on top of feeling rejected by the client (Pekarik, 1985a).

In addition to experiencing anxiety and heightened stress, novice therapists have difficulty maintaining emotional boundaries with clients because "the ability to strategically detach and reattach is a difficult, advanced skill" (Skovholt & Trotter-Mathison, 2016, p. 57). Emotional boundaries involve differentiating the self (practitioner) from the other (client); this differentiation is tricky for novices because they have not yet developed a professional self (Skovholt & Rønnestad, 2003). The development of the professional self takes time. Professional individuation is the gradual integration of the personal and professional self over the course of a therapist's career (Skovholt & Rønnestad, 1992), at around 10 to 30 years of practice. Not being able to differentiate the self from the client can lead to reacting to emotional overload with defensiveness and the continuous processing of the information from sessions, which is similar to rumination. As a result of underdeveloped emotional boundaries, novice practitioners might be more prone to overinvolvement than their experienced counterparts. Over-involvement means that practitioners are preoccupied with clients' distress, pain and other issues, even while off-duty. As one might imagine, overinvolvement is an antecedent of emotional exhaustion and burnout (Lee et al., 2011). Due to the overinvolvement with clients, novice therapists might experience an even greater sense of failure and rejection following premature termination of therapy. Novice therapists can have feelings of incompetence, a low or unstable self-concept, and doubts about staying in the profession (Hogan, 1964; Loganbill et al., 1982; McNeill & Stoltenberg, 2016; Owen & Lindley, 2011; Rønnestad & Skovholt, 2012; Skovholt & Rønnestad, 1992, 2003; Skovholt & Trotter-Mathison, 2016), so losing clients for unknown reasons may exacerbate such insecurities.

In a meta-analysis of the antecedents of burnout in psychotherapists (Lee et al., 2011), therapist over-involvement with client care emerged as being positively correlated with burnout and a sense of personal accomplishment. Over-involvement can give therapists a sense of accomplishment because the therapists feel like they are going the extra mile to help. However, seeking a sense of accomplishment by becoming too invested in clients' welfare is a pitfall that psychotherapists should be cautious of. Simionato and Simpson (2018) conducted a systematic review of literature on occupational stress, severity of burnout and personal risk factors for burnout in psychotherapists. Over-involvement, lack of work-life balance, perceiving an excessive caseload, fear of criticism, self-doubt, younger age, and less experience were identified as risk factors for burnout. Such risk factors are associated with being in the novice phase of

career development; novice therapists tend to be younger, inexperienced, overwhelmed by work, anxious about criticism and lacking in professional confidence (Skovholt & Rønnestad, 1992).

As a summary, the literature suggests novice therapists experience increased stressors due to their lack of internalized expertise, performance anxiety from being under scrutiny by supervisors and regulatory bodies, struggling to find the optimal level of attachment to clients (Skovholt & Trotter-Mathison, 2016), disillusionment, fluctuating self-concept, and loneliness (Rønnestad & Skovholt, 2012). Due to the predictably high stress levels, novice therapists are encouraged by some professors and supervisors to make a habit of practicing self-care. Typically, however, self-care strategies are not formally taught, but there are academic articles about therapist self-care. Additionally, some experts are of the opinion that self-care is the responsibility of the individual therapist rather than the training institution (Thériault et al., 2015). As such, novice therapists are unprepared for how to implement effective self-care strategies to cope with the stresses of the occupation (Kottler, 2022). If therapists do not take care of themselves, they risk burnout (Kottler, 2022) and in turn, impaired practice, which contravenes the *Professional Practice Standards for Registered Psychotherapists* (https://www.crpo.ca/standards-regulations/), is unethical, and harmful to clients. Self-care is a recommended strategy for countering the occupational hazards of being a psychotherapist (Norcross, 2000). In terms of self-care, simply being aware of the hazards and acknowledging them are effective strategies (Kottler, 2022; Rønnestad & Skovholt, 2012), as well as understanding that the hazards are universal among psychotherapists. The universality offers a sense of peer support, which in itself is therapeutic, as it lessens feelings of isolation. The study can contribute to novice therapists' awareness of the almost inevitable incidences of premature termination of therapy so that when it happens to them, they might have a balanced and adaptive view of the phenomenon. The knowledge of clients "ghosting" other therapists, and learning about how the therapists coped with it, would normalize and validate the experience for novices.

Prior Research on Premature Termination of Therapy

Overall, the research literature has focused on clients' experiences of premature termination of therapy because it is important to understand the reasons for premature termination and subsequent outcomes. Clients who drop out of therapy prematurely often have poorer mental health outcomes and continue to need services (Swift et al., 2012; Westmacott et al., 2010). It is arguably equally important to understand therapists' perspectives of premature termination of

therapy because they can experience burnout, a sense of failure, decreased job satisfaction and high job turnover as a result (Klein et al., 2003; Pekarik, 1985a). Much of the existing literature covers predictive factors of premature termination including client demographic variables, clients' reasons for premature termination and therapists' attributions as to why the clients left. Predictors of premature termination have been studied extensively and they include weak or damaged therapeutic alliances (Anderson et al., 2019; Safran & Kraus, 2014), and client demographic variables, such as low socioeconomic status (Wierzbicki & Pekarik, 1993). However, more recent research suggests not all client demographic variables are reliable predictors of premature termination of therapy, such as ethnicity, gender, level of education and marital status (Swift et al., 2012).

Reasons for premature termination of therapy vary across clients, and there has been research into whether those reasons differ depending on when the termination occurs in the therapy process, whether early on, or after at least several sessions. In a study by Westmacott and Hunsley (2017), psychologists responded to a survey, where they rated the importance of clients' possible reasons for ending therapy, based on when their clients dropped out. The reasons for client dropout were derived from prior research on premature termination of therapy, and they included clients' inability to afford treatment and dislike of the therapist or type of therapy they received (Westmacott & Hunsley, 2017). The results showed that when the psychologists' clients dropped out before the third session, they rated reasons such as the clients' lack of motivation to change as the most important, whereas for clients to dropped out after the third session, psychologists rated reasons such as symptom improvement as the most important (Westmacott & Hunsley, 2017). The study indirectly gathered data about the therapists' opinions of why clients dropped out, via ratings of importance. The use of survey responses estimating the importance of each reason clients might have dropped out do not provide much insight into how the psychologists experienced the phenomenon of client dropout.

According to a study of premature termination of cognitive-behavioural therapies by Bados et al. (2007), the majority of clients who unilaterally ended therapy did so between the first and fifth sessions. It is plausible that clients who terminate therapy in the early stage are dissatisfied with the therapy or therapist, and find it difficult to engage with them. Based on previous research, important reasons clients drop out of therapy include the mismatch between client and therapist expectations for therapy, and the lack of therapeutic alliance due to cultural

misunderstandings between the therapist and client (Vasquez, 2007). There is some evidence to suggest that therapists tend to expect and prefer a longer duration of therapy compared to clients (Pulford et al., 2008). As such, clients might feel like they are finished and ready to move on, so they end therapy, while the therapist views this behaviour as premature termination. Such an example once again points to the problem of varying definitions of premature termination of therapy, including between clients and therapists.

Research suggests therapists tend to have a self-serving bias, often attributing premature termination to factors such as a client's lack of motivation to change, rather than their own competence (Murdock et al., 2010). As such, there is a negative connotation to clients unilaterally ending therapy. However, Leichsenring et al. (2019) suggest psychotherapists consider changing their negative view of premature termination of therapy, instead seeing it as clients ending therapy that they found to be unhelpful. Premature termination of therapy can also be seen as impetus for devising treatments that are effective for use with a broader client base. Leichsenring and colleagues add that researchers and therapists should continue to learn about the process and function of psychotherapy by studying premature termination of therapy.

As previously stated, only one study used qualitative methods to gather detailed accounts of therapists' experiences of premature termination, apart from their views about what caused the termination. Piselli et al. (2011) used semi-structured interviews to ask therapists about a memorable case of premature termination within the past 10 years. Two out of their 18 interview questions inquired about therapists' emotional responses to the premature termination: "How did you feel when this client left therapy?" and "How did the departure of this client affect your sense of competence?" (Piselli et al., 2011). The 16 other interview questions covered the duration of therapy, whether the therapist noticed signs the client might drop out of therapy, what the therapist would do differently if they had a chance, and what advice the therapist would give to less experienced therapists regarding premature termination.

Piselli et al. state that therapists "Typically felt the termination had no effect on their sense of competence (e.g., 'I didn't feel it had anything to do with my competence')" (p. 407). However, therapists' emotional reactions to premature termination include guilt, responsibility, anger, frustration, surprise, confusion, relief, sadness, failure, and shame (Piselli et al., 2011). It is interesting to note that the emotions and reported causal attributions are inconsistent; feelings of guilt, responsibility and failure could reasonably be expected to be linked to feelings of

incompetence. Gathering more information about therapists' experiences of premature termination could guide future therapist trainings to include modules on adaptive and maladaptive coping strategies in response to premature termination. In addition to learning and discussing coping strategies, novice therapists would likely benefit from the normalization and validation of their experiences of premature termination of therapy. Novice therapists typically feel a sense of loneliness or isolation as they become autonomous after being accustomed to depending on professors and supervisors (Rønnestad & Skovholt, 2012).

Impact of Premature Termination on the Therapist

According to the existing literature, premature termination of therapy can have wide-ranging negative effects, from the costs to clients, therapists and mental health organizations. When clients prematurely terminate therapy, they might drop out before gaining the benefits of treatment. As such, the clients will continue to experience mental health issues and require further services (Westmacott et al., 2010). Therapists can experience reduced productivity, higher incidence of burnout, a sense of failure, and high job turnover in the wake of premature termination of therapy (Klein et al., 2003; Pekarik, 1985a). A sense of failure would add to the already common problem of feelings of incompetence among therapists (Thériault & Gazzola, 2010). Therapists who feel demoralized and rejected because of premature termination of therapy may be less effective in interactions with other clients. There is a risk that therapists would experience decreased confidence, anger, lower self-esteem, and narcissistic injury, which is a reduction in self-worth after a perceived failure. Such emotional and behavioural responses to premature termination can impair therapists' effectiveness in the job as well as affect their personal lives (Ogrodniczuk et al., 2005).

Based on research findings illustrating novice therapists' fragile sense of professional self, over-attachment to clients, and general eagerness to help clients achieve therapeutic goals (Skovholt & Rønnestad, 2003; Skovholt & Trotter-Mathison, 2016), one might intuitively expect that novice therapists would be more sensitive to the demoralizing effects of premature termination of therapy. The author's exploratory research was intended to yield data regarding novice psychotherapists' experiences of premature termination of therapy to identify what impact, if any, instances of premature termination of therapy had on their personal and professional selves. Research on ghosting in relationships suggests ghostees (victims of ghosting) perceive ghosting to be more unexpected and unfair than explicit rejection (Pancani et al., 2022).

As no explanation is given for the breakup, ghostees feel confused and uncertain, and they are unable to attribute the breakup to a specific cause. As such, ghostees might blame themselves. Ghosting involves ostracism (willfully ignoring someone), which is a painful experience according to social exclusion research. If therapists' experiences of premature termination are anything like the experiences of ghostees in romantic relationships, they could experience feelings of surprise, uncertainty, confusion, rejection, and a sense of unfairness (Pancani et al., 2022). Experiencing such feelings could pose a challenge to therapists' safe and effective use of self with other clients, since it might be difficult to be fully present, reflective, and focused on the client in sessions.

Rationale and Research Questions

Based on the research literature on therapist development, occupational stressors and client dropout, premature termination of therapy is difficult for therapists to deal with personally and professionally (Klein et al., 2003; Pekarik, 1985a; Piselli et al., 2011). However, there is a lack of detailed information about how therapists experience their clients prematurely terminating therapy. Due to the heightened stress of novice therapists, it is important to gather information about how they experience premature termination of therapy at this vulnerable stage of their careers. The current study was guided by the following research questions: 1. How do novice psychotherapists experience premature termination? 2. What, if any, was the impact of premature termination of therapy on novice psychotherapists and their practice? Understanding the post-termination process therapists go through could be beneficial in guiding therapists' self-care and professional development efforts. The impact of premature termination on novice psychotherapists is relevant and of great interest to the author as a master's student in counselling psychology and a novice psychotherapist. One goal of the study was to contribute to the scholarly literature on the experiences of novice therapists so that they might be able to better prepare for their work with clients. If novice therapists are trained to be cognizant of how premature termination of therapy might affect them, it could help them navigate the experience when it occurs. The findings could guide training, professional development and self-care efforts to include premature termination of therapy as an occupational occurrence and strategies for coping with such events. The methods of the study are intended to aid data collection from a target population and to provide rich descriptions of the experience of premature termination of therapy from the novice psychotherapist's perspective.

Methodological Framework (Methodology and Methods)

Participants

The sample consisted of seven novice psychotherapists in Ontario, Canada to gain insight into their experiences of premature termination of therapy. Purposeful sampling was used to recruit novice therapists who have experienced premature termination of therapy. Inclusion criteria were having less than five years of clinical experience, and fluency in English due to the monolingual information materials and interviews. The small sample size allowed for rich, in-depth data to be gathered from each participant. Demographic data such as race and gender were not collected, as they were not considered relevant to the research questions of the study.

Recruitment

The principal researcher searched the Internet for agencies including psychotherapists, then checked the practice websites to confirm the presence of at least one registered psychotherapist in the "qualifying". The title, "Registered Psychotherapist (Qualifying)" in Ontario typically denotes a new psychotherapist with less than five years' experience. Recruitment information (Appendix A) was shared with 33 mental health agencies in Eastern and Southwestern Ontario, Canada, requesting that the information be forwarded to their practitioners. Once the agency directors forwarded the information, they had no further role in who participated in the study. Recruitment information was additionally shared with members of the Canadian Counselling and Psychotherapy Association (CCPA) via a bulletin advertisement in the members-only Workspaces area of the CCPA website (https://www.ccpa-accp.ca).

Interested participants contacted the researcher directly by email. Participants were promptly emailed the consent form (Appendix B) containing pertinent information about the study so that individuals were able to provide informed consent prior to participating. The sampling for this study was purposeful rather than randomized, so participants were invited to forward the study recruitment info to peers who had similar experiences to volunteer for the study (a snowball sampling method).

Data Collection

Semi-structured virtual interviews were conducted via Zoom to collect data in the form of therapists' own descriptions of their experiences with premature termination. Interviews lasted between 25 and 60 minutes per participant, and they were recorded and transcribed using features of Zoom and Otter (otter.ai) applications. The interview questions (Appendix C) focused on the

therapists' understanding of themselves and what they were thinking, feeling and doing after experiencing premature termination of therapy by clients. The questions were open-ended and discovery oriented to allow the therapists to talk about the salient aspects of their experience in dealing with clients that drop out of therapy without forewarning or explanation. Asking questions such as "Can you tell me about an example of when a client dropped out of therapy with no explanation? What comes to mind when you think about that example?" and "How did you respond when you realized the client was not coming back? What were some thoughts and feelings you had at that time?" enabled the participants to talk about any salient aspect of their experience of premature termination. The questions avoided focusing on the client's role in premature termination of therapy and causal attributions, since previous research has covered those areas extensively. Additionally, from the perspective of ethical considerations, asking about the client's role in premature termination could have led to blaming or resenting the client(s).

The semi-structured interview schedule—or list of guiding questions—consisted of 11 open-ended questions related to the main research questions. The schedule was allowed to evolve over the course of the study to incorporate data from previous participants' interviews, which can aid in refining the questions and prompt participants to cover particular areas of interest (Fylan, 2005). For example, if previous participants mentioned high stress levels and wishing they could take time off from work, a question such as "What was your level of stress at that time? Did you take any time off?" could have been added to the schedule for subsequent participant interviews.

Using the same example, if a participant is not sure of what else to say about the experience of premature termination of therapy, a prompt could be helpful, such as "Some other participants talked about stress; what was your stress level like?" Another prompt during the interview process was to ask the participants for examples, during which the researcher will make observations and process notes about participants' affect, behaviours, and reported emotions. Process notes were useful for further prompting rich descriptions from participants, as in "It sounds like you were frustrated; can you tell me more about that?" or "Other therapists I've interviewed mentioned [insert topic]; what are your thoughts on that?"

Data Analysis

Once each interview was complete, the Otter transcription was compared to the original audio by the author and corrected to ensure accuracy. Structured Thematic Analysis (Clarke & Braun, 2017) was then performed on the data to identify and code meaningful common themes

from therapists' transcribed interviews. Thematic analysis involves coding key elements of data that are relevant to the research questions, then structuring the coded information into higher themes (Clarke & Braun, 2017). There are six phases of thematic analysis, which were performed in the proposed study.

During the first phase of thematic analysis, the interview data are transcribed, verbatim, and the transcription is checked for accuracy through comparison with the original audio recordings. Transcription not only creates written records of the verbal accounts obtained during interviews to be read and re-read for analysis, but the attention to detail and time spent on transcription fosters familiarity with the data (Braun & Clarke, 2006). The first phase additionally entails making notes about interesting features of the data.

The second phase involves creating initial codes from the data; codes are applied to segments of data to begin organizing the data into groups. The entire data set is coded, consistent with the inductive approach to thematic analysis, in which the aim is to provide a rich overall description of the data gathered in the study (Braun & Clarke, 2006).

Once initial codes have been applied to the data, the third phase of thematic analysis begins. The codes are analyzed for any overarching themes, and a visual thematic map can be developed to view how the codes relate to one another. By the end of phase three, the data are organized into coded segments related to main themes and sub-themes for further analysis.

In the fourth phase, the themes are reviewed at two levels: first reading the segments of data for each theme to see if they do indeed form a pattern, and second, re-reading the entire data set to assess whether the thematic map is an accurate representation of the meanings found in the data set. If coded data segments do not form a coherent pattern, the theme might be revised or discarded. If the thematic map does not represent the important meanings of the data set as a whole, items can be re-coded and the map can be revised. If new themes are identified, they can be added. By the end of the fourth phase, there is a map of the themes, their relationships, and a representation of the data overall.

The fifth phase of thematic analysis involves identifying what each theme captures about the data segments and how the themes fit together to represent overarching themes of the data overall. During this phase, themes are refined to ensure they do not overlap (Braun & Clarke, 2006). Upon completing phase five, themes and sub-themes are clearly defined and named. The names of themes are concise, meaningful, and easy to understand.

During the sixth and final phase of thematic analysis, the data analysis is written as a report. The report is an "analytic narrative" (Braun & Clarke, 2006; p. 93), in which an argument is made regarding how the data relate to the research questions. Data excerpts are included to demonstrate the validity of themes that were derived from the data.

Trustworthiness

The data collected from therapists in the study are subject to biases, such as errors in recollection and a self-serving bias whereby therapists might attribute premature termination of therapy to problems related solely to the client to preserve their sense of professional confidence (Piselli et al., 2011). Data were transcribed verbatim to accurately represent participants' narratives, and the transcriptions were checked for accuracy against the original audio recordings. During the coding phase of data analysis, codes were created based on relevant and meaningful portions of the data. Codes and subsequent themes derived from the data can be influenced by researcher bias, since the researcher chooses words and phrases that are meant to capture the meaning behind interviewees' statements. The chosen words and phrases are then put into the overall conceptual structure and related back to the research questions. As such, Structured Thematic Analysis (Braun & Clarke, 2006; Clarke & Braun, 2017) involves subjective interpretations. To reduce researcher bias, the author's interpretation of the data was audited by the thesis supervisor to refine codes and themes, and reach a consensus on them. The results of the study are a conceptual structure representing the lived experience of the participants. The auditing of the data interpretation was to ensure the viability and trustworthiness of the interpretation.

Results

Structured thematic analysis (Braun & Clarke, 2006; Clarke & Braun, 2017) was conducted to analyze and organize the data from seven participant interviews, resulting in five main, overarching themes: Therapist Responses to Being Ghosted, How Therapists Processed Being Ghosted, Nature of Therapy Termination, Aspects of Therapy Delivery, and Elements of Novice Therapist Development. Every interview transcript was checked for accuracy and coded by the principal author; the coded transcripts were then audited by the thesis supervisor. Once the data from the transcripts were organized into a conceptual structure (Appendix D), the thesis supervisor audited them again and provided feedback. For the purpose of reporting the results, clients' premature termination of therapy is conceptualized as "ghosting", because it fits with the

term in other settings and literature, such as dating relationships. The therapists and clients had some interaction, then the clients ceased all contact without giving any explanation (Pancani et al., 2022).

Table 1

Overview of Themes in Novice Psychotherapists' Descriptions of Being Ghosted

Main theme	Themes	Subthemes
Therapist responses to being ghosted	Response to being ghosted vs. response to other types of therapy termination	Feelings
		Cognitions
		Impact of ghosting
		Coping and self-care
		Influence of context on the impact of being ghosted
		Retention strategies
How therapists processed being ghosted	Normalization of being ghosted	Prevalence of ghosting, occupational hazard, advice for new therapists
	Attribution	Internalizing/externalizing
	Personalization	Taking ghosting personally
	Therapist view of clients' reasons for ghosting	Mentalization: rationalizing the ghosting by taking clients' perspectives
Nature of therapy termination	Warning signs were present/absent before ghosting	N/A
	Mutual decision to end therapy vs. client ghosting the therapist	N/A
Aspects of therapy delivery	Therapists' policies and procedures	Attempt/no attempt made to follow up with clients
		Feeling bad about enforcing no-show policy

Main theme	Themes	Subthemes
Elements of novice therapist development	Supervision is invaluable for novices	N/A
	Novice insecurity	N/A
	Over-involvement with client wellbeing	N/A
	Self-doubt	N/A
	Feelings of incompetence	N/A
	Gaining experience with dropout	N/A
	Ability to distance self from client	N/A
	Developing professional judgment and insight	N/A
	Preparedness for dropout	N/A

Therapist Responses to Being Ghosted

The first main theme consisted of various aspects of how the therapists reacted to being ghosted by clients, including their emotional, cognitive and behavioural responses, as well as mediators—circumstances that magnified or reduced the impact of ghosting on the therapists. Additionally, participants compared being ghosted to situations where terminating therapy was a decision that was discussed and agreed upon.

Table 2

First Main Theme and Related Subthemes

Main theme	Theme	Subtheme	Code	Verbatim examples
Therapist responses to being ghosted	Responses to being ghosted	Feelings	Negative (e.g.,) disappointment, confusion, self-doubt	P2 "I felt disappointed. I felt like there was more that could be worked on."
		Cognitions	Worry, rumination about client, processing	P6 "What could I have done differently?"

Main theme	Theme	Subtheme	Code	Verbatim examples
			Not ruminating	P2 "Maybe they'll come back, maybe they won't."
		Impact of ghosting	Self-soothing internal dialogue	P1 "I can't be doing everything wrong, because there are some who are still…here."
			Novice therapist worries about competence, being ghosted reinforces these worries	P4 "Am I a good therapist? Do I know what I'm doing? Did I actually deserve that RPQ title?"
		Coping and self-care	Taking a stance of acceptance	P6 "Making peace with things…It is what it is, I can't chase after people."
			Adjusting self-care to include processing and reflection about	P3 "For me, self-care is just taking the time to process it, like, it's okay to reflect on this."
			Self-care stable throughout	P7 "Self-care has been pretty stable throughout."
		Influence of context on the impact of being ghosted	Client vulnerability intensifies concern	P5 "Maybe they just don't need it…Those ones don't bother me. It's if somebody's vulnerable."
			Impact of ghosting made worse by client context: unsafe/unwell	P5 "I didn't know if (client) was okay. I didn't know what had happened."
			Impact of ghosting lessened by client context: Client had gone through several therapists	P5 "Had gone through several different therapists. So…that didn't stick with me."

Main theme	Theme	Subtheme	Code	Verbatim examples
		Retention strategies	Trying to improve retention of clients, seeking supervision.	P6 "There was also a lot more supervision about it…you know, what can I actually do to retain more clients?"
	Responses to other types of therapy termination		Positive (e.g.,) satisfaction	P7 "More closure."

Feelings

Participants described the emotions they experienced as a result of being ghosted, and some of the therapists compared their emotional responses to ghosting versus other types of therapy termination, such as therapist-initiated and mutual termination. The feelings about being ghosted were reported to be mostly unpleasant or negative, including shock, guilt, self-doubt, confusion, shame, frustration, disappointment, rejection, surprise, self-blame, hurt, fear about the fate of the client, feelings of incompetence, and a lack of closure. Although there may be some overlap between self-doubt and feelings of incompetence, self-doubt was a separate subtheme because participants repeatedly used the term "self-doubt", and it included doubts about the successfulness of the therapy for reasons beyond perceived incompetence. For example, Participant 1 stated, "Is there anything I could have done? Could I have done something different? Is it my price? Was it a financial reason?" Additionally, there was an implicit distinction between self-doubt and feelings of incompetence when Participant 2 said, "What could I have done differently? Or what could I have done better?" Therapists might doubt their performance in specific instances rather than feel incompetent overall, or they could experience both self-doubt and feelings of incompetence simultaneously.

Feelings of relief and enjoying more free time in the schedule were also reported. In contrast to ghosting, when the therapist and client came to an agreement about ending therapy, the reported emotions were pleasant or positive in nature, such as "satisfying" and having a sense of "closure."

Cognitions

Therapist cognitions about being ghosted involved "self-doubt," "rumination," wondering if they did something wrong, and worrying about the client's safety and wellbeing. Other cognitions consisted of self-soothing internal dialogue, such as "[I go] back and forth between like, that part of my brain that's telling me…I could have done something different, then the part that's…rationalizing it, right, saying like, 'these things happen.'" Other cognitive responses included not ruminating about the ghosting and taking a stance of acceptance, whereby the therapists mentally wished the clients well and then focused on the clients who remained in therapy.

Impact of Ghosting

The therapists in the study described the effect ghosting had on them personally and professionally, forming the theme of Impact of Ghosting. The aftermath of ghosting led to therapists wondering about the fate of the lost client, experiencing imposter syndrome and feelings of incompetence, questioning their career choice, trying to get closure by following up with clients and talking with peers about the issue, pining for a response from the client, and sensitivity to possible warning signs indicating clients may drop out. A beneficial effect of ghosting was the free time created in the therapist's schedule when they were desiring a lighter caseload. One therapist sought coaching from their supervisor to prevent the ghosting incident from affecting their interactions with clients:

> I had to find closure, because I felt if I didn't, I would have let that affect…further interactions maybe with those clients who did end therapy, but also perhaps others, just day to day, like any sense in the session that 'Oh, will they go?' and maybe think back to those previous clients and say, 'Well, they did, why won't this person?', so I felt like I needed to kind of stop myself so that I could continue really fruitful therapeutic relationships with all my other clients. (Participant 4)

Coping and Self-Care

Participants reported dealing with ghosting by taking time to process and reflect on what happened, seeking supervision and peer support with colleagues, taking a stance of acceptance, focusing on the good alliances with remaining clients, and rationalizing the ghosting to achieve a sense of closure. An additional method of attaining some closure was to build client autonomy and skills into each session so that there was a sense "the client will be okay" if they drop out. Self-care strategies included walking, massage therapy, reduced work hours, travel, socializing

with friends and family, reading, daily exercise, sleep hygiene, nutritious diet, spending time outdoors, taking time to unwind after work, balancing work and life, prayer, and scheduling clients based on the amount of energy and focus is needed. The majority of participants reported their self-care did not change following being ghosted. The most common coping strategy after being ghosted was to seek supervision regarding the incident.

Influence of Context on the Impact of Being Ghosted

The impact of being ghosted was either intensified or reduced by contextual information such as the client having a pattern of dropping out of therapy with other therapists, or the client having medical problems. Participants expressed that the impact of being ghosted was exacerbated by other sources of stress, "If I had a particularly stressful day, then I was harder on myself about it", countertransference, and the client's level of vulnerability and safety, such as being unwell, not having other supports, or being in an abusive relationship. One participant explained that being ghosted by a client for whom they had strong countertransference produced self-doubt, whereas being ghosted by other clients was easier to cope with; the same participant also said experiencing ghosting for the first time was harder than subsequent times.

Retention Strategies

Following ghosting incidents, participants described strategies they developed to retain clients, including pre-emptive actions to try and prevent ghosting in the future. Three retention strategies were identified from the data. The first was offering a referral to a different therapist if the client expressed dissatisfaction, which typically resulted in the client staying to give the process another chance. The second strategy was to ask the supervisor how to improve client retention. The third was to initiate a discussion about the frequency of sessions and future rebooking; the therapist offered flexibility, so the client could rebook and then cancel if the session was no longer needed, or gradually schedule sessions farther apart and if they needed to help sooner, the therapist would promptly book them in. One participant gave the example:

> I'll kind of bring up like, Do you wanna maybe stretch out sessions, and I'll always say to clients…just email me, and we can book you in…So I might push them more to like, either not rebook, or rebook in six weeks, and then just cancel it if they don't feel like they need it. (Participant 5)

The flexibility of scheduling appeared to take pressure off the client, perhaps preventing ghosting, because the client had ample opportunities to cancel a future appointment or to not book one at all.

Responses to Other Types of Therapy Termination

When comparing ghosting (unilateral premature termination of therapy by the client) to mutual therapy termination and therapist-initiated termination, ghosting was described as feeling "bad" while the other types, especially mutual termination, felt "a lot better." Therapists reported positive experiences of concluding therapy in a planned manner, such as having closure, feeling happy for the client and feeling somewhat sad to see them go. With a planned end to therapy, therapists described being able to prepare for the final session, and the option of the client returning for future services was left open.

Table 3

Second Main Theme and Related Subthemes

Main theme	Theme	Subtheme	Code	Verbatim examples
How therapists processed being ghosted	Normalization of being ghosted	Prevalence of ghosting	Perceived universality	P3 "It happens and it's part of the job. It's going to happen, whether you have one year experience or twenty."
		Occupational hazard		
		Advice for new therapists		
	Attribution	Internalizing	Feels responsible	P5 "We don't have control over what people do…But…I still carry it a little bit."
		Externalizing	Externalizing reason for ghosting – client unable to declare termination when satisfied.	P2 "The original thing that brought them into therapy was resolved, but they didn't know how to say it's resolved."

Personalization		Ghosting feels personal due to good alliances, attachment to clients	P5 "I do feel connected to most clients that I see. So then it always kinda feels personal."
Therapist view of clients' reasons for ghosting	Rationalizing reasons for ghosting from client's perspective (mentalization)	Clients may be unable to address their desire to quit directly	P2 "They don't know how to break up with you."

How Therapists Processed Being Ghosted

The second main theme in the data involved descriptions of how the therapists processed the experience of being ghosted by clients. that after the shock and confusion caused by being ghosted, participants analyzed the ghosting incidents to gain a better understanding of what happened and why. Some therapists tried to pinpoint the cause of the ghosting, while others accepted the ambiguity of the situation more readily. Through reflection and supervision, participants came to realize that being ghosted by clients is a very common occurrence; the experience was normalized for them, and in turn, they wished to normalize it for newer therapists who might read this research paper.

Normalization of Being Ghosted

Prevalence of Ghosting. Most therapists participating in this study reported that they have been ghosted more than once, and one indicated it has happened "a lot…it's common."

Occupational Hazard. Participants recognized that client dropout is a common occurrence in the field, along with ambiguity and lack of closure. One therapist noted, "There's always going to be a little bit of disappointment and reflection…how were we a good fit? How weren't we a good fit?" while others said "[ghosting] happens and it's part of the job", "We're in this weird field that we don't get answers…there's a lot of unanswered questions to live with," and "The closest I've come to closure is maybe just talking with other people, finding that reassurance… normalizing it."

Advice for New Therapists. The main message the study participants had for new therapists is that ghosting happens and it's normal. Other words of wisdom included "You've made it this far, you gotta be doing something right", "Garner the confidence and the passion that you have for therapy and know that there's gonna be people that appreciate that, so keep going",

ghosting is probably "not about you as much as you think", "It happens to most therapists…the feelings that come with it are valid…take care of yourself through self-care", and "It is inevitable…and it's going to happen for a variety of reasons…it's not always the therapist's fault.

Attribution

Related to the cognitive aspects of the experience of being ghosted by clients, therapists ascribed the ghosting to internal (therapist) causes, external (client) causes, or they took a neutral stance, in which they viewed the ghosting as a result of the lack of fit between themselves and the client. Fit is another term for therapeutic alliance or working alliance (Bordin, 1979), which is how well a therapist and client can work together towards the therapy goals. Examples of internalizing the ghosting are "Was it my price?", and "Wondering if I said something that made (the client) not feel safe anymore." Examples of externalizing the ghosting are "(The client) probably just wasn't ready for change," "I see it as, it's about them," and "clients drop out for a variety of reasons, that are usually a lot more personal to them than it is about the therapist." One therapist with a neutral perspective said, "I don't think it's anyone's fault. Maybe it was just the wrong timing."

Personalization

Some of the participants took it personally when clients ghosted them, and it appeared that the ghosting particularly stung in certain circumstances. For example, when the therapist thought there was a good therapeutic alliance with the client who dropped out, it reportedly felt personal because of their attachment to the client. As one participant worded it, "I do feel connected to most clients that I see. So then it (ghosting) always kinda feels personal." Ghosting was also taken personally when the therapist viewed client retention as a reflection of self-worth, "If I'm good enough, people will stay." An additional example of the personalization of ghosting was when a participant described how tricky it was to "parse out the personal from professional" self. The participant illustrated the use of self in therapy as, "It's not just talking to somebody like you're at the bank…You're using, not just yourself, but your soul to speak with people and be there with them."

Therapist View of Clients' Reasons for Ghosting

Similar to making external attributions for the ghosting, there was a subtheme of mentalization, where the therapists attempted to see the situation from the clients' perspective. Participants speculated clients' reasons for ghosting such as avoidant attachment style, not

wanting to have a difficult conversation, and not wanting to hurt the therapist's feelings, "They want to just be able to walk away without…having to have a hard conversation. Same reason that people ghost on dating."

Other speculative reasons for dropout included financial restrictions, unreadiness to engage in therapy, inability to address their desire to quit directly, inexperience with the therapy process, satisfaction with progress and disinterest in delving deeper into other issues that could be worked on. One therapist viewed varying levels of client engagement in therapy from a needs-based perspective, so as clients' needs change, engagement and attendance in therapy also change.

Table 4

Third Main Theme and Related Subthemes

Main theme	Themes	Subthemes	Codes	Verbatim examples
Nature of therapy termination	Warning signs were present/absent before ghosting	Lack of engagement	Multiple cancellations, rescheduling	P1 "They just kind of disappeared without a trace."
	Mutual decision to end therapy vs. client ghosting the therapist	Comparing types of therapy termination	Ending therapy mutually, or therapist-terminated therapy feel better than being ghosted	P5 "Definitely better if you feel like you and the client have come to an agreement that it's ending."

Nature of Therapy Termination

The third main theme contained descriptions of how the termination of therapy occurred, specifically, if there were warning signs prior to the client dropping out, and whether the termination was a unilateral choice by the client (ghosting) or a mutual decision with the therapist.

Warning Signs Were Present/Absent Before Ghosting

Four of the seven therapists interviewed reported there were no warning signs prior to their clients ghosting them. One participant said only in hindsight could they see that the client had cancelled sessions multiple times, and the client's initial presenting issue had been resolved, so the client might have wanted to end therapy at that point but did not tell the therapist directly.

A second participant reported that the warning sign they detected was the client's issue was resolved. Other warning signs before ghosting included the client being detached and not engaging in therapy sessions, lack of therapeutic alliance, rescheduling sessions, not responding to emails, wanting to be able to book appointments with the therapist but not being ready to engage in the therapy process yet, deteriorating health, and lack of engagement in the first session.

Mutual Decision to End Therapy vs. Client Ghosting the Therapist

Participants were asked if they had any examples of clients giving advance notice before ending therapy and how those situations compared to being ghosted. As previously mentioned, ghosting was generally described as a more negative experience other types of therapy termination because of the lack of closure. By contrast, instances when the therapist and client agreed to conclude therapy, it was:

> Because they have either reached a goal, or unfortunately, their insurance has run out, or some other circumstance where it was very clear. That feels a lot better than *poof*, they just disappear, because you have an answer…because there is closure, not just for yourself, but for the client as well. (Participant 6)

When clients told therapists in advance that they would be ending therapy, the therapists were able to adjust their plans for sessions and ensure clients have skills for managing their mental health on their own. One example from the data was a therapist who always tried to "Make…clients be their own therapists and learn their own skills and techniques. And so there was kind of this sense, they're going to be good." A different therapist described how mutual termination of therapy was a very positive experience, and "better" than being ghosted:

> I gently brought up the topic, and they seemed kind of relieved that I brought it up and then we talked it through and we kind of did a really pretty quick but end session and it was really good. And I felt, we feel really good about it. That's like the perfect scenario in my mind is that everybody's on the same page. Definitely better if you feel like you and the client have come to an agreement that this, it's, it's ending and everybody's comfortable with when it's ending, how it's ending. (Participant 5)

Table 5

Fourth Main Theme and Related Subthemes

Main theme	Themes	Subthemes	Codes	Verbatim examples
Aspects of therapy delivery	Therapists' policies and procedures	Attempt/no attempt made to follow up with clients	Client does not reply to attempted follow-up	P4 "No explanation did not follow up to 'when would you like to book next'."
			Therapist does not 'chase' client	P2 "Whenever clients do [drop out], I respect that, whatever their reason is, for wanting to discontinue therapy. I never chase them."
		Feeling bad about enforcing no-show policy	Finds it hard to charge clients who don't show up, but has improved over time	P5 "I find it hard to charge people like if they no show, but I've gotten better at it. And that's been through…help from the admin."
	Process-outcome discrepancy		Process and outcome discrepancy: it's going well but they disappear	P1 "They had told me how well it was going…how much therapy was helping them."
	Alliance	Importance of therapist-client fit	Lack of fit might interfere with client engagement/retention	P2 "It was a good therapeutic connection, but not good enough that they could tell me that they wanted to end [therapy] and they weren't gonna come back."

Aspects of Therapy Delivery

The fourth main theme was made up of descriptions about how the therapists provided services to the clients. Participants spoke about their policies and procedures, as well as issues related to their therapeutic relationship with clients. Some therapists had a policy to follow up with clients who ghosted them, while others did not. One therapist mentioned they had difficulty enforcing the no-show policy with clients who did not attend appointments but with the help of

clinic staff, they were gaining confidence in being able to enforce it. There was a theme of how important the fit is between the client and therapist; from the therapists' perspectives, the quality of the therapeutic alliance influenced whether or not clients ghosted them. Sometimes the lack of fit was apparent to the therapist, but other times therapy seemed to be going well and the client would express how helpful it was, yet they would still ghost the therapist.

Therapists' Policies and Procedures

One facet of practice was either attempting to follow up with clients who ghosted them or not attempting to follow up. Some of the therapists viewed following up as "chasing" clients, which to them, would not be respecting the client's autonomy and choice. One therapist worded it as, "If they really want to, they'll contact me again." It is unclear from the data whether attempting to follow up with clients affected the clients' decisions to ghost rather than give explanations for ending therapy. As a standard procedure across practices, all of the therapists sought guidance from their supervisors when they were ghosted by clients. One therapist reported they have a procedure of eliciting feedback from clients at the end of each appointment, so "If there's…something they do want to change, they have an opportunity to mention it."

Feeling Bad About Enforcing No-Show Policy

One participant reported "I find it hard to charge people, like, if they no show, but I've gotten better at it." With help from the clinic staff who emphasized the importance of enforcing the policy, the participant reflected on how "You're sitting there in front of your computer at your office, like, waiting for that person, it's your time, and then you don't get paid for it."

Process-Outcome Discrepancy

The participants described instances where therapy process seemed to be going well, the therapeutic alliance felt strong to the therapist, yet the client ended up ghosting them. These data formed the theme of process-outcome discrepancy. Examples include "It's not…a good feeling when they leave, especially when…you see all this growth, you see all this progress in the work you're doing, and then they disappear," "I thought it went really well and we had booked next session. [The client] cancelled and never contacted me again," and "I'm able to connect with them and they still might ghost. And I think that's a really confusing aspect of it."

Alliance

The subtheme of alliance encompassed descriptions of the 'fit' between clients and therapists. Participants emphasized the importance of fit, and they suggested that a lack of fit

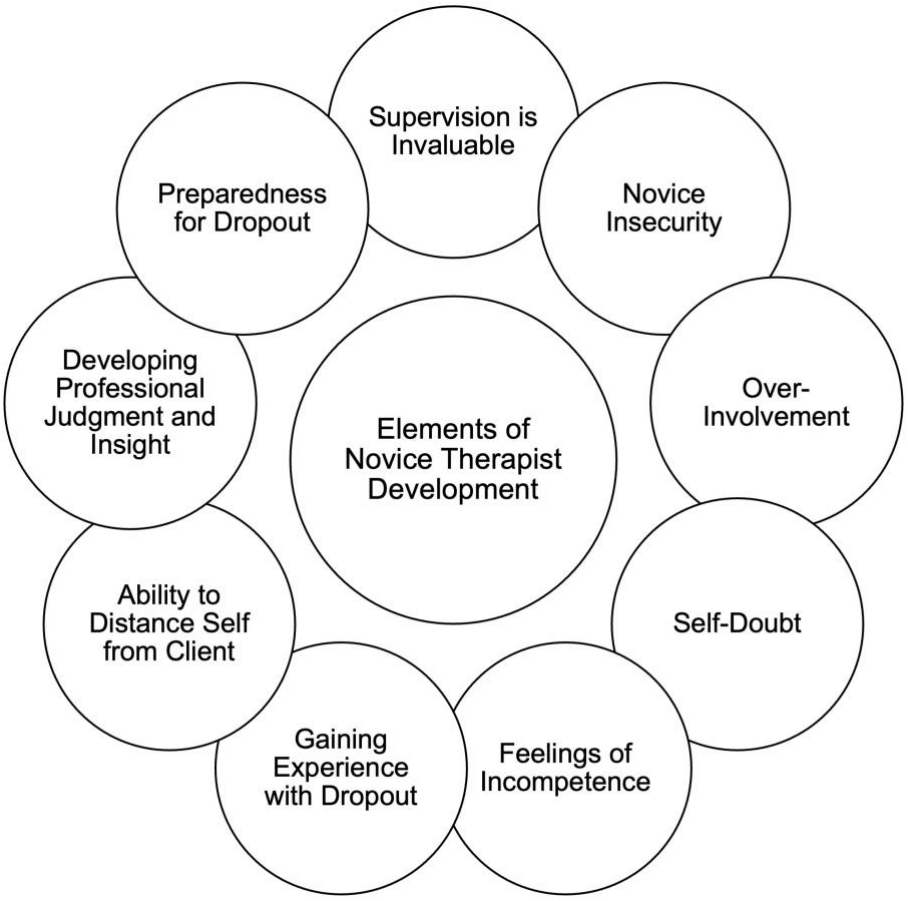
might have contributed to clients ghosting them. One therapist attributed ghosting to a lack of fit, "If it's a good fit, they'll keep coming. And if it's not what they need at that moment, sometimes they might disappear." Another therapist noted, "Sometimes you get a really good sense of, 'oh, like, we really click, this is great', but they might not feel the same way." Some participants mentioned they were ghosted by clients temporarily, then the clients returned months later. In these cases, therapists worked on rebuilding the alliance by remaining non-judgmental and welcoming the client back. Other aspects of the alliance theme included a client being attached to the therapist and did not engage after the therapist returned from vacation, having alliance problems due to the client's avoidant pattern in all relationships.

Elements of Novice Therapist Development

The fifth and final main theme (Figure 1), comprised multiple topics within the study data regarding areas of career development for the participants, including their level of awareness of client dropout, experience they have gained on the job, and issues of insecurity and self-doubt.

Figure 1

Fifth Main Theme with Related Subthemes



Supervision is Invaluable for Novices

The most prominent subtheme in therapist development is the importance of supervision because every novice therapist interviewed for the study said supervision was helpful in processing and coping with being ghosted by clients. Supervisors validated the therapists' feelings about the ghosting, normalized the occurrence, reassured the therapists that clients drop out for many reasons that are not always related to therapist effectiveness, and provided coaching in strategies to help retain clients. Some of the novice therapists had little to no prior experience with repairing alliance ruptures, which made it difficult to identify ruptures as they occurred and to address them with the clients. In hindsight, one therapist recognized a possible rupture prior to the client ghosting them and said, "I perhaps…pushed in a direction that maybe seemed too much for them." Another therapist said their supervisor reassured them that the client dropping out was not likely due to an alliance rupture by the therapist: "Hearing from the person who knows how I work and stuff like that, that it was okay, was helpful at that time."

Novice Insecurity

According to the data, the therapists often responded to being ghosted with negative affect, self-doubt and feelings of incompetence. One participant explained their development towards a more secure professional self as the following:

> I think we all, as new clinicians or even all clinicians in the field, everyone, they feel competent based on if clients show up. Right? So I feel like, hurt…personally, I've kind of developed that, you know, kind of just keeping my ego stable even when clients don't show up or if they drop out, my worth as a person or a therapist are kind of the same, which is something I preach to all my clients, like self-worth being stable. So it's something that I've tried to absorb as well. (Participant 7)

Over-Involvement

Novice therapists can be preoccupied with their clients' problems, and they can be over-invested in the clients' wellbeing (Skovholt & Rønnestad, 2003). Three features of over-involvement appeared in the data as the following codes: Emotional boundaries that are very flexible or porous, over-attachment to clients, and feeling overly responsible for clients. Porous emotional boundaries mean the therapist is not yet able to have an optimal level of emotional distance from the client (Skovholt & Rønnestad, 2003). One therapist described experiencing all three characteristics of over-involvement:

> I can get attached to certain clients, and kind of feel responsible for them more than I should…I have to be super careful about those boundaries. I love working with them, I connect well with them. I think it's people that I feel don't have their own supports. And then you kind of wonder if, like, you're the only person in their life, and that they're maybe putting all this weight on what you're saying, which is a huge, huge responsibility. (Participant 5)

Self-Doubt

Participants described questioning whether they did something wrong when clients ghosted them: "I was already feeling that self-doubt, it just kind of reinforced it,", "Did I say something? Did I go too fast? Is this my fault?", and "It's always hard when clients choose to end it a little bit, because there's always a little bit of that self-doubt that comes in." Doubting one's performance or delivery of therapy as a service was prevalent in the data.

Feelings of Incompetence

Therapists in this study expressed feeling incompetent and doubting their effectiveness as therapists. Participants noted such sentiments as, "I still have those doubts, that imposter syndrome and that kind of thing," and receiving supervision reassured them "That it's okay to have like those days where like that self-doubt creeps in and doesn't mean that we're actually doing something wrong." Normalizing feelings of incompetence was reportedly helpful because it provided a distinction between feeling incompetent and being incompetent. Another therapist reported:

> I felt incompetent right away. It kind of trumped all my other positive experiences as a student. You know, as a new practitioner, I immediately went to the idea that okay, I guess I'm not competent. So it hurt my ego for sure and made me question my skills, my readiness at that point in time. (Participant 7)

Gaining Experience with Dropout

Some participants shared what they have learned since the first time a client dropped out. One therapist stated the many variables they have noticed, that can lead to a client dropping out, such as "Finances, moving, therapist and client not fitting, certain modalities not being the best for them. Or even transference, right, a client may perceive something that the therapist did." Another therapist said, "The more it happens, the easier it gets to kind of like put it aside."

Ability to Distance Self from Client

Unlike porous emotional boundaries where the therapist self is not yet differentiated from the client, one participant acknowledged having a different perspective from the client, "I might have my own perception and my own assumptions. But I'm not the client. And I don't experience things as they, as they do." This demonstrates the ability to distance the self from the client, which suggests the therapist has optimal emotional boundaries instead of porous emotional boundaries, which would lead them to be over-involved in the client's problems.

Developing Professional Judgment and Insight

Some participants described developing internalized knowledge and becoming more comfortable using their own judgment rather than relying solely on external sources of information like books, professors and supervisors. As examples, one therapist demonstrated intuitively recognizing ruptures to the alliance with clients, "If you really have a gut feeling that maybe there was a rupture, or somehow it was your fault. I think it is," and a second therapist conveyed having insight into choosing modalities to suit clients, "One thing I've learned, because I'm pretty psychodynamically inclined, younger clients benefit less maybe from insight-oriented therapy. They just want to be heard and supported."

Preparedness for Dropout

Participants had varying levels of awareness and experience with client dropout when they started practicing. The topic of dropout was covered more extensively in some university programs than others. One therapist said:

> It was definitely mentioned in my master's, when we're talking about counselling, but it was not focused on as much as I think it should be. I didn't really put a lot of energy into, 'Oh, well, what if they leave?' (Participant 4)

A second therapist said client dropout was adequately covered in their university program, providing some exposure to client dropout during the courses and practicum:

> I feel like we were really well prepared for those dynamics of like, sometimes people won't come back, I had friends in the program that, starting out, they would have had like, three or four clients start with them and quit. And so you're seeing, you're hearing about it from the people. (Participant 5)

A third therapist reported:

> I was really aware of this, I knew it happens all the time for, again, a variety of reasons. Not having to do with the therapist's skills. And I also know sometimes it's just not a good

> client-therapist fit. So I knew there's a variety of reasons and that it was going to happen to me over and over again. Over time. Despite knowing it happens, still made me curious about what led to it. (Participant 7)

Discussion

The research questions that guided this exploratory qualitative study were 1. How do novice psychotherapists experience premature termination? 2. How do novice psychotherapists perceive the impact of premature termination of therapy on their sense of professional self and their practice? The data provided rich information about the experiences of seven novice psychotherapists who had been ghosted by clients.

Main Findings

Novice therapists generally responded to being ghosted with self-doubt, and they disclosed that premature termination of therapy can exacerbate the already present feelings of incompetence (Thériault & Gazzola, 2010). Other responses to being ghosted included those similar to ghostees in dating relationships: Hurt, surprise, confusion, uncertainty, and rejection (Pancani et al., 2022). Cognitions and behaviours were reportedly impacted by ghosting, in that some of the therapists ruminated and worried about the clients who dropped out, engaged in coaching specific to client retention, and altered their schedule. While some therapists attributed the ghosting to external causes, self-doubt and feelings of incompetence were pervasive in the data, suggesting these participants likely did not have a self-serving bias, which differs from previous research (Murdock et al., 2010).

There were some unexpectedly positive aspects to being ghosted, such as feeling relieved and having more free time. Similarly, participants in Piselli et al. (2011) expressed they did not feel premature termination of therapy had anything to do with their competence, yet their emotional responses were guilt, responsibility, frustration, surprise, anger, confusion, relief, sadness, failure and shame. The present results are consistent with the emotional experiences reported by Piselli et al. except participants in this study were registered psychotherapists with less than five years' experience, and they reported that premature termination of therapy made them feel incompetent and even made them question their career choice. Participants in the Piselli et al. study were board-certified psychologists aged 40 and above, with at least 15 years' experience. It appears the emotional responses to ghosting are similar across therapists of varying experience levels, but the impact of ghosting on their sense of competence is different. The

seasoned therapists in the study by Piselli et al. (2011) generally viewed their own work positively and attributed the ghosting to client factors, while most novice therapists in the current study doubted their own competence and blamed themselves when clients dropped out of therapy.

All of the participants in this thesis research acknowledged that it is common for clients to drop out of therapy without explanation, yet it was a struggle to process when it happened to them, especially when they first started practicing. Some of the therapists reported ghosting has become easier to deal with over time and experience. Supervision was invaluable after being ghosted, and the participants particularly found the normalization of ghosting in the profession beneficial. As one participant put it, "There was a, especially the first time, like a big sigh of relief to just have that normalized for me."

Therapist-client fit was mentioned frequently in the data, indicating the therapists' understanding of how crucial the fit is for therapy to be effective; they opined that if clients do not feel they match well with the therapist, they may drop out of therapy and ghost them. In previous literature, it was suggested that therapists can adjust their attitude towards premature termination of therapy to be less negative and less personalized, instead focusing on how a lack of fit would have been detrimental to the client (Leichsenring et al., 2019). However, the ambiguity surrounding ghosting makes it difficult to attribute the cause to lack of fit, especially as a novice therapist, who might tend to blame themselves. One participant ascribed the ghosting to lack of fit but it did not make processing the experience any easier, due to ambiguity:

> I don't take that personally, I encourage clients to do the therapist-shopping to look around to make sure that there is somebody that they're comfortable talking with. But if they don't say it, of course, we're left with questions and wondering, you know, did they ever find somebody? Was it the right fit? (Participant 6).

Premature termination of therapy was generally viewed negatively by the novice psychotherapists, but the results of this study indicate there are mediators such as contextual information and attribution style (externalized versus internalized responsibility) that can influence the impact of being ghosted. When a participant learned that the client who ghosted them saw several other therapists and dropped out on them, that participant viewed the ghosting incident in a new context, which was that the client was difficult, and the participant no longer took the ghosting personally. Context could also make a therapist feel worse about a ghosting incident, which is what happened

when therapists in the study learned about a client being in an abusive relationship, and a different client having medical problems. When such clients dropped out of therapy, the therapists were more worried about the clients' safety and wellbeing than other less vulnerable clients who quit therapy. Internalizing the cause of the ghosting appeared to coincide with rumination, worrying, feelings of incompetence and guilt because the therapists blamed themselves, whereas externalizing the cause of the ghosting seemed to be associated with acceptance of the situation. Therapists who externalized the cause to client factors, or neutral factors such as a lack of fit in the therapeutic relationship, described less rumination and self-blame. A pertinent example of an externalizing attribution style was, "Often, it's not about you. It's about them and what they're going through."

According to some of the novice therapists, there are a few positive aspects of being ghosted by clients, for example, freeing up time, and gaining insight into what works and what might not work for certain clients. In general, the results of this study suggest being ghosted by clients is difficult to process and cope with despite prior knowledge of how common it is, the lack of closure resulting from ghosting is hard to tolerate, and being ghosted is mostly seen as an unpleasant part of the job.

Alignment with Literature on Therapist Development

This study adds to the research on therapist development, as several subthemes in the data supported some of the classic developmental theories. According to previous literature on therapist development, novice therapists have trouble detaching from clients (Skovholt & Trotter-Mathison, 2016) and maintaining emotional boundaries, which differentiate the self (therapist) from the other (client) (Skovholt & Rønnestad, 2003). It is possible that being ghosted as a novice therapist is more emotionally painful due to the over-attachment and lack of emotional boundaries than it is as a seasoned therapist. The subtheme of Feeling Bad About Enforcing No-Show Policy provides support for previous literature on novice therapists' general lack of confidence and their tendency to focus on giving clients abundant positive feedback (Hill et al., 1981). From the novice therapist perspective, it may seem harsh to enforce financial penalties for clients because it involves a form of punishment.

The results validate previous research showing that novice therapists doubt their own competence (Thériault & Gazzola, 2010), since at this stage of development, therapist self-concept alternates between feeling competent and feeling incompetent (Loganbill et al., 1982).

Most of the novice therapists interviewed in the thesis study expressed feeling self-doubt and they questioned their competence. According to Rønnestad and Skovholt (2012), it takes time for therapists to transition from having a fragile practitioner-self to a stable practitioner-self. In the interviews for the current study, participants reported internalizing and personalizing the experience of being ghosted, doubting their career choice, and seeking reassurance from their supervisors because the ghosting negatively impacted their professional confidence. The thesis data seemed to support the theory that as therapists develop a stable professional identity, their awareness of self and others is refined (McNeill & Stoltenberg, 2016), meaning they are better able to differentiate the self from the client and have stronger emotional boundaries (Skovholt & Rønnestad, 2003). One therapist demonstrated distancing the self from the client by recognizing that the client can have a different and unique perspective on how therapy is going.

Some of the participants reported ruminating about the ghosting, worrying about the clients who ghosted them, wishing they could have done more for the clients, and feeling like they might be the only support resource the clients had. Such experiences support the concept of novice therapists being preoccupied with clients' issues, being over-invested in the clients' wellbeing, and feeling overly responsible for clients (Skovholt & Rønnestad, 2003).

Over the course of therapist development, practitioners increasingly rely on internalized knowledge rather than solely relying on external sources, such as books and supervisors (Owen & Lindley, 2011). Participants in this study illustrated developing internalized knowledge and judgment by suggesting there is a gut feeling associated with ruptures in the therapeutic alliance, and by reflecting on how their chosen therapy modality might not be effective for some clients.

Implications for Practice

The overarching theme of the results is that premature termination of therapy happens, it is a normal and inevitable part of the job. The participants found it particularly helpful to know it happens to all therapists, not just them; they reported being reassured when supervisors and peers commiserated with their experiences. As such, novice psychotherapists would likely gain from open discussions about ghosting with their supervisors and colleagues, because this would normalize and validate the experience. If ghosting is as common in the field as the participants, their supervisors, and previous literature suggest, then why are new therapists still shocked and riddled with self-doubt when it happens to them? Perhaps the subject needs to be emphasized sooner, during formal education.

The novice therapists made self-care a habit to cope with the stresses of the occupation, including being ghosted by clients. The strategies included regular physical activity, reading, driving, spending time socializing, and unwinding after work. The therapists' self-care did not change much as a result of being ghosted; the routines were well established and continued after the ghosting. Other novice therapists would likely benefit from engaging in self-care early in their careers, possibly even getting into a routine of self-care before they start practicing. There are so many new experiences to navigate when they begin practicing, it would likely ease stress to already have a self-care regimen in place rather than creating one while handling all the other required tasks on the job. One self-care strategy was used specifically after being ghosted by clients, and that was seeking supervision about the situation. The therapists found it helpful to discuss what might have gone wrong in those cases and learn about client retention strategies, although the most beneficial part of supervision was validation and normalization of what they were going through.

Based on the results of this study, therapists who externalized the cause of ghosting described having less rumination and self-blame. Perhaps adopting an external attribution style would help novice psychotherapists cope with client dropout like their seasoned counterparts: With a self-serving bias (Murdock et al., 2010). Attributing dropout to external factors such as client financial restrictions may help novices let go of some of the self-blame and guilt they reported experiencing. However, as Murdock et al. (2010) noted, by attributing premature termination of therapy to client factors, they could essentially blame the clients, which would be detrimental to resuming or repairing the relationship with those clients. If therapists harbour resentment or judgment towards the client for ghosting them, the client would detect those negative feelings. A therapist in the current study wisely observed that after clients drop out temporarily and come back, the therapeutic alliance is easier to re-establish if the therapist remains non-judgmental and welcoming.

The data suggest the use of client retention strategies might help prevent ghosting, particularly having open discussions with clients about how and when they want to end therapy. Novice therapists could benefit from perhaps asking the client what their plan is for the remaining sessions, whether they would like to schedule them and then cancel if they no longer need the appointments, or not book future sessions and wait to see if they need another session. Keeping this line of communication open could help novice therapists and their clients navigate the

subject of therapy termination, which can feel awkward, and it puts clients in control of scheduling, possibly reducing the pressure they feel to rebook with the therapist even if they don't need any more therapy.

Along with open communication, novice therapists might enhance client retention by practicing a high level of self-awareness and consider the possible effects of privilege, power imbalances. According to research by Vasquez (2007), clients from ethnic minorities terminate therapy prematurely at high rates, possibly partially due to ruptures and a lack of fit with their therapists. As such, when a cultural match between clients and therapists is not possible, therapists can do their best to ensure they do not unintentionally perpetuate stereotyping, discrimination, and micro-aggressions with clients (Vasquez, 2007).

Implications for Therapist Education and Training

Normalization of ghosting in formal education and practicum settings would be beneficial for preparing new therapists to handle it effectively and more confidently. The novice psychotherapists interviewed in this study all had some level of awareness of client dropout, but the topic was not extensively covered in their university programs or practicum training. Two therapists said, "My program did mention it…I don't think I was aware of how often it happens," and "In my program, they did warn us this could happen. And I had to keep reassuring myself that it happens." A third therapist reported:

> It (client dropout) was definitely something I did not think about on a regular basis. I was a little shocked when it first happened. It was definitely mentioned in my master's, when we're talking about counseling, but it was not focused on as much as I think it should be.

A fourth therapist stated that client dropout was only mentioned in passing, and it was not taken seriously in their education program or their practicum. Throughout the thesis study, novice therapists reported how helpful it was to have their supervisors and peers normalize being ghosted by clients. It would likely be reassuring to have premature termination of therapy normalized during formal education, before starting to practice, so it would be less of a shock when it inevitably occurs.

According to previous research, novice therapists are prone to over-involvement in clients' cases (Skovholt & Rønnestad, 2003) and they feel overly responsible for them. Data from the present study support such findings. It is plausible that novice therapists would benefit from guidance on *how* to develop optimal emotional boundaries to avoid over-involvement, since

emotional boundaries are yet another vague, ambiguous concept to individuals who are new to practicing. It is unknown whether some of the struggles typical to novices could be avoided, but it might be worth trying. Multicultural counselling is another subject that can help novices approach therapy with cultural humility and responsiveness, potentially preventing ruptures and some instances of premature termination of therapy.

Delimitations

The study was conducted in English, and the sample consisted of English-speaking therapists in Ontario, Canada. Research interviews took place via videoconferencing during the COVID-19 pandemic.

Limitations

The sample of seven novice therapists was small, and the resulting themes derived from the data may not be representative of the experiences of all novice therapists. The data consists of subjective reports that were then coded and interpreted by the student researcher, so despite taking measures to ensure the viability and validity of the data analysis such as the supervisor's auditing of the analysis, there may be some researcher bias in which aspects of the data were focused on. The student researcher is a novice psychotherapist who could relate to the experiences of the participants; reflecting on the researcher-as-instrument, it is possible that the student researcher influenced the participants during interviews by relating, normalizing and validating what they were saying through nods and smiles.

Future Directions

It could be worthwhile to continue researching therapists' experiences of premature termination of therapy with a focus on whether teaching and normalizing the subject in formal education would mitigate the impact on novice psychotherapists' sense of competence. Instead of recruiting a sample of therapists in the novice stage by using the criteria of less than five years clinical experience, future studies could break down the novice stage of development by recruiting samples of participants in their first year of practicing, second year of practicing, and so forth, to explore any differences in their experiences with premature termination of therapy. Samples could also be categorized by number of hours or number of clients seen, to account for differences in experience levels rather than using years as the sole indicator of their stage of therapist development. Future research could focus on how the normalization of being ghosted helps novice therapists feel reassured; does normalization reduce feelings of isolation and self-

blame? Does it matter who does the normalizing, whether it is peers, professors, or supervisors? Based on the data gathered for the thesis, it would seem supervisors hold the most power to reassure novice therapists.

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Appendix A: Recruitment Advertisement

Hello,

My name is Lianne Saxon and I am a master's student in the Counselling Psychology program at the University of Ottawa. I am conducting thesis research under the supervision of Dr. Anne Thériault, psychologist and professor in the Faculty of Education. The purpose of the study is to learn about the experiences of novice psychotherapists when clients drop out of therapy without any explanation or follow-up.

Participant criteria:

- Registered Psychotherapists (Qualifying or full RP) in Ontario, Canada, with less than 5 years clinical experience
- Had a client or clients drop out of therapy unexpectedly, prematurely, and without any reason given
- Proficiency in English, as the study is conducted in English
- Participants do not have to be currently practicing

Participation in the study will consist of a one-to-one virtual semi-structured interview via Zoom, which will take approximately 45-60 minutes. The questions will include topics such as what you thought, how you felt, and what you did when you realized the client(s) had dropped out. With your consent, the interview will be recorded and transcribed for data analysis. Interview responses will be anonymous in the research paper to respect confidentiality.

This study has been reviewed and approved by the Research Ethics Board at the University of Ottawa.

If you are interested in volunteering to participate in the study, or you have questions about participating, please contact me at [REDACTED]. I will promptly respond to your email to schedule a brief phone conversation with you for the purpose of screening for eligibility to participate. Upon confirming that you meet the inclusion criteria and that you would like to proceed with volunteering for the study, I will email you the Letter of Information and Consent document containing complete details about participation. For additional questions about the research, you may also contact my supervisor at [REDACTED].

Sincerely,

Lianne Saxon
Registered Psychotherapist (Qualifying)
MA (Ed.) in Progress
University of Ottawa

Appendix B: Information and Consent Form

Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

University of Ottawa
Consent Form for Master's Thesis

Project title: Novice Psychotherapists' Experience of Premature Termination of Therapy

Names of researchers and contact information:

Lianne Saxon
Master's student
Faculty of Education
University of Ottawa
Email [REDACTED]

Anne Thériault, Ph.D.
Psychologist
Associate Professor
Counselling Psychology
University of Ottawa
Email [REDACTED]

Invitation to Participate: I have been invited to participate in a research project conducted by Miss Lianne Saxon under the supervision of Anne Thériault as part of her master's thesis at the University of Ottawa.

Purpose of the Study: The purpose of the study is to gather in-depth data about how novice psychotherapists experience premature termination of therapy, specifically when a client drops out of therapy after attending more than one session, without giving any reason or having any further contact with the therapist.

Participation: My participation will consist of participating in one semi-structured interview about my experience related premature termination of therapy. The time needed for this is approximately 45-60 minutes. The interview will take place as a virtual meeting at a time convenient to me. Miss Saxon will record my responses and transcribe them for use in her final written thesis without using my name or other identifying personal information.

Assessment of risks: My participation in this study entails no foreseeable risks. If I experience any discomfort, Miss Saxon has assured me that she will make every effort to minimize this discomfort, such as taking a break or debriefing after the interview. I may decide to not answer certain questions, or to stop the interview at any time.

Benefits: By providing information about my experience with premature termination of therapy, I am contributing to the greater understanding of the phenomenon as it pertains to novice psychotherapists.

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Ottawa ON K1N 6N5
Canada

www.uOttawa.ca

Privacy of participants: I have received assurance from Miss Saxon that the information I share will remain strictly confidential. My identity will be protected, as Miss Saxon will not include any identifying information about me or my client in her thesis. Contextual information including client names, names of clinics/practices, and the names of towns/cities will also be anonymized.

Confidentiality and conservation of data: The data will be used for the purpose of the master's thesis and will be kept for 5 years. I have been assured that the audio recording will be kept in a secure manner at the researcher's home during the research and then stored on a password-protected uOttawa cloud after the study ends. In 5 years, all material data will be shredded and electronic data will be erased.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____ [*Name of participant*]*,* agree to participate in the above research study conducted by Miss Lianne Saxon for her master's thesis, at the Faculty of Education, University of Ottawa under the supervision of Anne Thériault**.** I will receive a copy of the consent form for my records.

If I have any questions about the study, I may contact Miss Saxon or Anne Thériault.

If I have any ethical concerns regarding my participation in this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa at [REDACTED]

Participant's name Date:

Lianne Saxon

Researcher's name Date:

Appendix C: Interview Schedule

1. Can you tell me about an example of when a client dropped out of therapy with no explanation? What comes to mind when you think about that example?

2. Did you have any idea the client was going to quit therapy?

3. How did you respond when you realized the client was not coming back? What were some thoughts and feelings you had at that time?

4. How did you make sense of what happened? If there was a sense of closure, how did you achieve that?

5. How did you feel about yourself at that time? How did you feel about your practice?

6. When you started practicing, how aware were you, that some clients would drop out of therapy?

7. A) What were the effects of the client dropping out? What impact did it have, short term and long term?
   B) Can you tell me about your self-care strategies before, during and after the client dropped out?

8. What have you learned about yourself, personally and professionally since the client(s) dropped out?

9. Do you have any examples of clients telling you in advance that they were ending therapy with you? If so, how did that situation compare to being ghosted?

10. What would you like new therapists to know about the experience of clients dropping out?

11. Are there any other aspects of your experience with premature termination of therapy that you would like to share before we end our interview?

Appendix D: Conceptual Structure

Themes	Subthemes	Codes
Therapist Responses to Ghosting	Feelings	• Disappointment, confusion, self-doubt, self-blame, shocked, puzzled, guilt, frustration, shame, rejected, surprise, relief, hurt, sadness
	Cognitions	• Worries about client safety and wellbeing, rumination about client, self-reassurance, wonders if they did something wrong, taking a stance of acceptance, imaginary correctives, fabricating explanations, internal dialogue – self-soothing, self-compassion
	Attribution	• Externalizing or Internalizing
	Impact of Ghosting	• Therapist senses lack of fit, relieved when client does not engage in therapy with them • Ghosting adds worrying to the therapist's existing self-doubt. • Had to regain confidence after ghosting • Greater impact on professional self than personal self • Long-term effects: None or can be long-lasting; built resiliency towards client dropout after the first time, lasting worry and thoughts about client, intrusive thoughts about client, wondering, lack of closure.

Themes	Subthemes	Codes
Therapist Responses to Ghosting (Continued)		• Short-term effects: Reflection, self-doubt, worrying about client, thoughts about client were consuming before using self-care strategies, heightened anxiety, repeated thoughts about client, gradual sense that they won't hear from client, being ghosted becomes less difficult over time
	Coping and Self-Care	• Obtains coaching in supervision, accepts uncertainty, rationalizing reasons for ghosting allows for sense of closure and less rumination, wishes clients well, focuses on remaining clients, has strong support network of family, friends, partner, seeks peer supervision, faith and prayer, reading, going for a drive, taking a bath, walking, massage, reduced work hours, travel, socializing with friends, good sleep and diet, exercise, unwinding after work, spending time outside
	Therapist View of Client Qualities	• Client avoids difficult conversation of ending therapy—same reason as ghosting in dating; avoidant attachment style, financial restrictions, unreadiness to engage in therapy, inability to address their desire to quit directly, inexperience with the therapy process, changing needs, satisfaction with progress and disinterest in

Themes	Subthemes	Codes
Therapist Responses to Ghosting (Continued)		delving deeper into other issues that could be worked on
	Mediators	• One client's ghosting had greatest impact due to countertransference • Particularly impacted by the ghosting because was implementing new more mindful style of pacing • Impact of ghosting exacerbated by client's level of vulnerability and safety—more worrying and rumination
	Personalization	• Client dropout feels personal because despite good alliances, clients ghost therapist; • Client ghosting is reflection of therapist worth
	Retention Strategies	• Offering client flexibility in spacing out sessions near end of therapy, offering to refer to other therapist when client expresses dissatisfaction—client typically stays
	Response to being ghosted vs. Response to other types of termination	• Frustration, guilt, shame, self-blame, lack of closure, does not leave option open for resuming therapy in future • Satisfaction, bittersweet, closure; ending therapy mutually, and therapist-terminated therapy feel better due to closure; could prepare, good communication

Themes	Subthemes	Codes
Normalizing Ghosting	Occupational Hazard Advice for New Therapists Prevalence of Ghosting	• Universality of ghosting, ambiguity, uncertainty of the field, ghosting is inevitable, common, it happens
Nature of Termination	Warning Signs: Present/Absent Ghosting/Agreed Upon Lack of engagement	• No warning vs. lack of engagement, multiple cancellations, rescheduling
	Comparing Types of Termination	• Ghosting viewed as negative experience vs. mutually deciding to conclude therapy
Aspects of Therapy Delivery	Policy and Procedure	• Does not 'chase' client, or client does not reply to attempted follow-up
	Difficulty Enforcing No-Show Policy	• Finds it hard to charge clients who don't show up but has gotten better at it over time
	Process-Outcome Discrepancy	• Therapist felt session went well but client disappeared, was careful about timing but feels timing may have been off, discrepancy between client declared level of engagement and actions
	Alliance	• Trust hard to re-establish with client who temporarily ghosted but remaining non-judgmental helps, client over-attached to therapist and never returned after therapist went on vacation, alliance problems due to client's avoidant pattern in relationships, can have good alliance yet still be ghosted

Themes	Subthemes	Codes
Therapist Development	Supervision is Integral	• Supervisors give reassurance, normalize ghosting, reaffirm therapist did nothing wrong, share wisdom about clients expressing their preferences through actions such as dropping out, advice to follow up with clients but not chase them
	Novice Insecurity	• Self-worth tied to client retention
	Over-Involvement	• Over-attached to certain clients, feeling overly responsible for clients, porous/weak emotional boundaries—overly invested
	Self-Doubt	• Wonders what they did or said wrong to make client leave, questioning career choice and ability to be a therapist
	Feelings of Incompetence	• Being ghosted triggers and exacerbates feelings of incompetence, exacerbates imposter syndrome
	Gaining Experience with Dropout	• The more it happens, the easier it gets; learned ghosting happens for a variety of reasons, not always therapist's fault
	Able to Distance Self from Client	• Recognizes therapist perspective can be that therapy is going well but client's perspective is different

Themes	Subthemes	Codes
Therapist Development (Continued)	Developing Professional Judgment and Insight	• Learned some modalities are not well suited to some clients, able to trust gut feeling about ruptures in alliance
	Preparedness for Dropout	• Therapists have varying levels of preparedness and awareness; not always covered adequately in formal education; felt prepared but still shocked when ghosting happened to them