

Anticipated Therapist Absences: The Therapist's Lens

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ANTICIPATED THERAPIST ABSENCES: THE THERAPIST'S LENS

by

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ABSTRACT
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Graham Knowlton, M.S.

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Over the course of a therapist's career, absences from work are inevitable. Although therapist absences undoubtedly impact the therapy process, the topic has not received sufficient attention to produce helpful guidelines. Instead, clinicians looking to the literature for recommendations find less in peer-reviewed journals regarding therapist absences than they would if they were to turn to popular media geared toward a client audience (Barchat, 1988). This study sought to begin to remedy this research gap using a Consensual Qualitative Research (CQR) research design focusing on anticipated therapist absences. Ten therapists with at least two years of experience post-licensure were asked about their general thoughts and approach to absences and the training they had received regarding therapist absences. They were also asked to discuss in depth a time that they were absent during therapy with an individual, adult client, focusing on the period before, during, and after the absence, as well as its overall impact. Participants reported generally receiving minimal or no formal supervision or training regarding therapist absences, and experiencing emotional distress when thinking about absences as a whole. When asked about specific absences, however, participants reported experiencing more positive than negative emotions, creating a plan with the client, and generally achieving positive outcomes. Implications are discussed, including recommendations for training, clinical work, and future research.

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Graham Knowlton, M.S.

It is difficult to believe I have reached the end of my journey through graduate school, and that all its accompanying trials are now behind me as I approach the beginning of my career in psychology. It is a surreal feeling and a strong sense of accomplishment that could not have been achieved without help along the way from too many people to be mentioned here. To those I am about to mention, your support cannot be measured. To those whom I encountered in the past six years but do not mention here, I appreciate many of your influences as well.

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TABLE OF CONTENTS

ACKNOWLEDGMENTS.....	i
LIST OF TABLES.....	viii
CHAPTER	
I. INTRODUCTION.....	1
II. REVIEW OF THE LITERATURE.....	6
Definitions.....	6
Empirical Literature.....	9
Types of Absences.....	17
Related Concepts.....	17
Object Relations.....	18
Separation.....	19
Attachment.....	20
Working Alliance.....	20
Termination.....	21
Therapist Self-Disclosure.....	22
Ethical and Legal Considerations.....	22
Considerations Affecting the Break.....	25
Therapy Setting.....	25
Multicultural Considerations.....	27
Client Factors.....	29
Therapist Factors.....	32
Time in Therapy.....	33

Reactions.....	34
Client Reactions.....	35
Therapist Reactions.....	37
Suggestions From the Literature.....	39
Pre-Absence.....	39
During the Absence.....	42
The Substitute Therapist.....	43
Post-Absence.....	47
Training.....	48
Conclusions and the Current Study.....	49
III. METHOD.....	51
Participants.....	51
Participation Criteria.....	51
Participant Demographics.....	52
Client Demographics.....	53
Absence Demographics.....	53
Research Team.....	53
Biases.....	54
Design and Procedures.....	54
Recruitment.....	56
Data Analysis.....	57
IV. RESULTS.....	59
Training Received Regarding T Absences.....	59

Emotions/Thoughts Regarding T Absences.....	59
General Approach to Absences.....	60
PT Relationship.....	62
What P Did During Absence.....	62
What C Did During Absence.....	62
P's Pre-Absence Thoughts/Feelings About Absence.....	63
P's Thoughts/Feelings About Absence During Absence	64
P's Post-Absence Thoughts/Feelings About Absence.....	64
C's Pre-Absence Thoughts/Feelings About Absence.....	64
C's Thoughts/Feelings About Absence During Absence.....	65
C's Post-Absence Thoughts/Feelings About Absence.....	65
P's Approach to Absence (prior)	65
P's Approach to First Session Post-Absence.....	67
C's Reaction to P's Return.....	67
Factors Complicating Absence for P.....	68
Factors Facilitating Absence for P.....	68
Impact of Absence on P.....	69
Impact of Absence on C.....	69
Impact of Absence on PT/Rx.....	70
Impact of Absence on Future Absences.....	70
Impact of Absence Overall.....	70
What P Would Do Differently Regarding Absence.....	70
Advice to Other Ts.....	74

Why Participated.....	74
Experience of Interview.....	74
V. DISCUSSION.....	76
Contextual Findings.....	76
Training Received Regarding Therapist Absences.....	76
Therapists' Thoughts and Feelings About Their Absences.....	77
Therapists' Approach to Absences.....	79
Specific Event Findings.....	80
Pre-Absence.....	80
Therapists' Thoughts and Feelings About Their Absences.....	80
Clients' Thoughts and Feelings about Therapist Absences.....	81
Therapists' Approach to Absences.....	82
During Absence.....	84
Post-Absence.....	85
Thoughts, Feelings, and Reactions About Therapist Absences.....	85
Therapists' Approach to Return From Absence.....	86
Overall Outcomes.....	87
Concluding Thoughts.....	89
Limitations.....	89
Implications.....	90
Training.....	90

Practice.....	91
Research.....	92
Conclusions.....	94
REFERENCES.....	95
APPENDIX A: DEMOGRAPHIC FORM.....	99
APPENDIX B: INFORMED CONSENT FORM.....	101
APPENDIX C: INTERVIEW PROTOCOL.....	104

LIST OF TABLES

TABLE 1. Contextual (i.e., not specific event) Findings.....	61
TABLE 2. Specific Event Findings.....	71
TABLE 3. Concluding Findings.....	74

I. Introduction

No matter how controlled or ideal an environment we attempt to create in the therapy room, we are often forced to recognize that therapy itself is but a small sliver of life, and life is not perfect. Extra-session events intersect with, or even interrupt, the therapeutic process. This assertion is true for both client and therapist, regardless of how diligently each may try to prevent it. Therapists are human, and as such they occasionally face conflicts between life and work.

The most unique aspect of the profession of psychotherapy, and a distinguishing quality, is the client-therapist relationship, found to be the most important factor in predicting therapeutic outcome (Kolden & Howard, 1994). No two therapists administer the same treatment in the same way, even if the only differences are minute personality factors. This fact means that no two therapists are interchangeable. Even if this were the case, however, and two therapists managed to perform their job in an unrealistically identical manner, one could still not be substituted for the other in the middle of the therapeutic process without there being an effect. Therapy is a dyadic process as opposed to a solitary one. Both client and therapist play integral parts in the outcome, and their interpersonal interaction is a key factor. Trust and intimacy are built over the course of therapy, and those interpersonal developments cannot be readily transferred to another therapist.

This dissertation investigates a phenomenon that forces therapists to confront these relational considerations on a regular basis: interruptions in individual therapy caused by anticipated therapist absences. For many different reasons, workers may be unable to perform their normal duties. They may be sick, a family emergency might

suddenly arise, or they may simply need a vacation. Such circumstances apply to therapists as well, even if they attempt to limit their absences to protect their clients. Absences can be either voluntary or involuntary, planned or unplanned. The truth is that most fall somewhere along those continua, and are more difficult to clearly define in such terms than one might expect. Thus, this study did not attempt to distinguish between these varied definitions of therapist absences, but instead focused on therapist absences that can be anticipated, regardless of the cause or intent.

Understanding therapist absences as a whole, as well as their role in the therapeutic process, could increase therapists' competence regarding how such absences can be addressed before, during, and after the event (Barish, 1980; Bush, 1989; Siebold, 1999; Webb, 1983). Without a solid empirical base to lean on, it is not possible to formally cultivate a standard of competence during training. As an evolving profession that deals centrally with the reality of life, we must look to incorporate training around the inevitabilities that will arise in our own lives and affect our clinical practice, such as our own absences. Absences do not always need to be seen as a disruption, or a negative event. They could instead be used as a part of the process, and could potentially be transformed into a positive event for the client when possible and appropriate. In this sense, they could serve as a practice termination that could elicit a great deal of information and be a huge part of the learning process, with the safety net of being able to process the event with the therapist instead of the client having to deal with any anxieties on her/his own with the finality of a fully-terminated relationship.

To the writer's knowledge, based on extensive searches of the literature as well as statements made therein, there is much yet to be uncovered in the realm of therapist

absences (Barchat, 1988; Barish, 1980; Bush, 1989; Chiaramonte, 1986; Cullington-Roberts, 1994; Kohut, 1971; Langs, 1973; Sable, 1992; Sanville, 1982; Sarnat, 1991; Schafer, 2002; Siebold, 1999; Stein, Corter, & Hull, 1996; Ward, 1984; Webb, 1983; Wolberg, 1988). Barchat (1988), Barish (1980), and Chiaramonte (1986) all used the word, “scant” to describe the literature on interruptions in the therapy process, and Barchat (1988) added, “this researcher was unable to discover a single empirical study focusing on patients’ responses to therapists’ vacations” (p. 30). Bush (1989) found “no published investigation that systematically explores therapists’ views of their own vacations as planned treatment interruptions” (p. 1). Thirty years ago, Webb (1983) stated, “neglect of the topic of the subject of therapists’ vacations is even more pronounced than avoidance of the subject of termination, another separation experience which also lacks the intensive study its significance merits” (p. 126). Webb (1983) then incorporated survey results into the quoted article “to rectify the neglect of the topic...in the literature, and [call] attention to the need for additional study related to the subject” (p. 133). Almost a decade later, Sarnat (1991) published a theoretical article as a way to add to the literature after looking for suggestions for a personal upcoming absence and finding “surprisingly little literature...on the topic of therapist absence in general” (p. 650). Stein et al. (1996) backed up this point five years after that, stating that “empirical studies of the effects of treatment interruptions on therapy patients are rare indeed” (p. 514). Finally, even more recently, Schafer (2002) referred to therapist absences as “a gold mine of insight” (p. 64). Barchat (1988) astutely noted that much more attention has been given to the topic of therapist absences in popular literature and popular media than in peer-reviewed journals. The writer found the same to be true today, finding popular

articles intended for clients, while encountering great difficulty locating professional literature, either empirical or theoretical, that specifically addressed the topic of therapist absences (Burson, 2006; Lewak, 2009).

It is difficult to deny that “absences must be recognized as an integral part of the process of therapy” (Hare-Mustin & Tushup, 1977, p. 531). During therapy, we are constantly working toward the ultimate absence: termination (Hare-Mustin & Tushup, 1977). How is it, then, that while termination is held as the goal toward which to strive, events that can be viewed as “practice rounds” are not fully understood or embraced? How can an area of such concern to clients not be empirically addressed by the professionals who treat them? How can such a consistent outcry from practitioners and researchers exist in the literature over decades, and yet remain unanswered, including by those crying out? The literature review sought to shine light on some of these questions and guide the study that follows in a direction that warrants investigation.

To begin the literature review, some key terms are defined, and the empirical literature is presented and critiqued, followed by a statement about the gaps in the literature. Different types of absences are briefly mentioned, and some theoretical lenses and related concepts are briefly discussed to give the reader an idea of the perspectives from which the cited authors drew. Ethical considerations are addressed, as they are always primary in any therapeutic decisional process. Next, different factors are considered that could have an effect on how therapist absences play out, such as the therapy setting, timing in the therapy, and multicultural considerations. From there, potential impacts of the therapist’s absence are discussed, before examining suggestions posed to help therapists manage their absences, separated into three stages: before the

absence, during the absence, and after the reunion. Subsequently, the state of training surrounding the topic is discussed. Finally, the writer's conclusions are conferred, along with a brief description of the current study.

In order to review the relevant literature in a comprehensive manner, varying types of literature were examined, and a variety of different search methods were employed. Types of literature reviewed included published, peer-reviewed journal articles, both empirical and theoretical in nature, books, book chapters, doctoral dissertations, and webpages on professional psychological organization websites. In some instances, information was drawn from peripheral sources that make no mention of absences due to the lack of literature directly addressing the chosen topic.

The main databases used in searches were through the Marquette University website, and included Academic Search Complete, PsychInfo, MARQCATplus, WorldCat, and Dissertations and Theses Global. In addition, Google Scholar was used as a secondary search option. The relevant results of these searches were compiled and stored in RefWorks, again through the Marquette University Libraries website. Examples of searches that were input into the noted engines were: *therapist absence*, *therapy absence*, *therapy interruption*, *therapy disruption*, *therapy break*, *therapist vacation*, *therapy vacation*, *therapist illness*, *therapist leave*, *therapist holiday*, and *therapy termination*. The writer also referred to relevant sources contained in the references sections of sources uncovered in the initial searches.

II. Review of the Literature

Definitions

In order to maintain consistency and understanding throughout this paper, certain terms must be defined. First, the range of what constitutes a *therapist* must be set. There are multiple fields in which the job description includes performing therapy of some type. The first parameter, then, will be that the term, *therapist*, refers to a professional practicing in the field of mental or behavioral health. The next question that must be answered when attempting to define this term is the scope of practice within the field. There are many different ideas as to what therapists do. Sable (1992) offered an idea as to what makes up the role of a therapist, as described by providing “the conditions in which to explore current and past experiences, especially those related to attachment, separation and loss, helping patients re-appraise and reconstruct their inner representations of attachment relationships with others” (p. 271). Although this description captures at least some of the components of what a therapist can do, and there are many people in the field who would agree with this assertion, there is likely also a large number who would say that it does not fit with their personal approach, or their professional identity. As I do not believe that there is one definition that encompasses all aspects of what makes someone a therapist, I will not attempt to provide such a definition. Instead, for the purposes of this paper, I will use a fairly generic description of the term, *therapist*. *Therapist*, then, will refer to someone who has attained at least a Master’s-level degree in a mental health field, is either licensed or license-seeking, and who sees a minimum of one client on a regular basis as a part of his/her job activities.

The next term which will be used throughout this exploration is *therapy*. Again, this is a term that will encompass a wide array of activities depending on the therapist's orientation, the population with which the therapist works, and many other client and therapist factors. One definition offered is as follows:

Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behavior, and (3) promoting positive personality growth and development. (Wolberg, 1988, p. 3)

This definition is a largely encompassing description of psychotherapy. For this paper, I will adopt the definition with one minor addition: I would also like to include the behavioral aspect of psychotherapy, as opposed to addressing solely the emotional side. The definition that I will use for the term *therapy*, then, adapted from Wolberg (1988), is, the treatment, by psychological means, of problems of an emotional or behavioral nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behavior, and (3) promoting positive personality growth and development.

The last term that will be explicitly defined at the start of this paper is *therapist absence*. As with other terms previously mentioned, there are many viable conceptualizations, or definitions, that could fit for *therapist absence*. Although I have not found a peer-reviewed definition specifically addressing *therapist absence*, there are some descriptions that are offered pertaining to interruptions in the therapeutic process in general, as well as alternative considerations about how to conceptualize therapist absences. Schafer (2002), for example, contended that the physical presence of a therapist

does not automatically mean that the therapist is psychically present with the client. Conversely, the point is also made that when a therapist is physically absent, whether during the usual time between sessions or during a longer break in therapy, it does not necessarily mean that the therapist is psychically absent from the client. The key idea here is that the physical aspect only makes up a part of presence versus absence. While I find this point to be valid, this paper will be examining primarily the therapist's physical absence, and its surrounding factors.

Peck (1961) described interruptions in psychoanalysis as, "breaks in the continuity as absences of the therapist for vacations or other reasons, vacations of the patient, and premature termination of the analysis" (p. 209). As stated, this describes a concept that is more general than that which I am aiming to explore in this paper, in that it encompasses a broader range of circumstances that contribute to interruptions in therapy. It can be used as a building block, however, for the definition I ultimately decide upon. As this paper will focus specifically on the absence of the therapist, the client's absence will obviously not be used within the definition. Secondly, premature termination will not be included within the definition of *therapist absence* in this paper, as I would like to distinguish between termination, where the therapy relationship is ended, and temporary breaks in therapy, where the goal is continuation. As a result, in order to qualify as an absence, the break must be temporary.

Therefore, *therapist absence* will represent a break in the therapeutic process that is not a regularly occurring event, such as the time between sessions, where the plan, or expectation, is to continue therapy, and therapy does indeed continue after the break. If therapy does not resume, then it is in fact a termination, not an absence. Also, if therapy

involving the same therapist and client resumes after a termination, that will not be considered an absence. Instead, that is a termination followed by a new therapeutic process restarting with the same members. The reason for this differentiation is that when a temporary upcoming absence, or break in therapy, is the expectation, a different process plays out than when the expectation is a permanent termination. These would be handled differently before, during, and after the absence, and so there are aspects of the two scenarios that are fundamentally different, even if a terminated therapy reconvenes after a shorter amount of time than a proposed temporary absence. There can be much learned about absences from termination, as they do indeed share significant overlap in some aspects; however, they are also different in key ways, and must be conceptualized as two distinct processes.

Empirical Literature

As has been noted, and will continue to be demonstrated throughout this examination, literature directly focusing on the topic of therapist absences is scant. There are only a few anecdotal articles that are derived from authors' clinical experience, and fewer still that address the topic empirically. Indeed, the lack of literature regarding therapist absences, or even temporary separations during the therapy process in general, has been an identified issue in the field for decades now (Barchat, 1988; Barish, 1980; Bush, 1989; Chiaramonte, 1986; Cullington-Roberts, 1994; Kohut, 1971; Langs, 1973; Sable, 1992; Sanville, 1982; Sarnat, 1991; Schafer, 2002; Siebold, 1999; Stein et al., 1996; Ward, 1984; Webb, 1983; Wolberg, 1988). In fact, some of the literature cited in this paper was developed specifically because the authors were not able to rely on other literature for advice when they had an upcoming absence and did not know how to

approach it themselves. An example of this was given by Sarnat (1991), when describing her experience leading up to a seven-month sabbatical. She wrote, as we saw earlier, that she looked “to [the] lit[erature] for help in making sense of my experience in managing the leave, but found very little. In fact, surprisingly little literature exists on the topic of therapist absence in general” (p. 650). Almost twenty-five years later, I had the same experience as Sarnat (1991). Some authors ventured to explain the dearth of literature, with ideas ranging from psychoanalysts in the past failing to recognize the analyst’s part in the process (Schafer, 2002), to a purposeful avoidance of the topic due to therapists’ discomfort with the acknowledgement that they could negatively affect the client by tending to their own realistic needs (Webb, 1983). Due to the practical non-existence of empirical literature in this realm, the studies that have been carried out will first be presented to provide a base for the rest of this review. The aim is to give the reader an understanding of what the field has had to work with in terms of research in this area, as well as a frame of reference for the rest of the review.

During this search for literature, only four empirical studies were found that directly addressed therapist absences (Barchat, 1988; Bush, 1989; Stein et al., 1996; Webb, 1983). If more exist, they are not readily accessible, and looking for such articles is like trying to find a needle in a haystack due to their paucity. This is knowledge in and of itself, as the search conducted in preparation for this literature review was likely much more extensive and time-consuming than most practitioners would be willing to perform, or would even know how to conduct without the aid of a specialist librarian. I am definitely not alone in my searching woes. Barchat (1988) stated, “this researcher was unable to discover a single empirical study focusing on patients’ responses to therapists’

vacations” (p. 30). We must use what we can, though, and examine the studies that do exist, to see what they covered, as well as what they may have missed.

The first study that directly addressed therapist absences looked at therapist vacations (Webb, 1983). Specifically, Webb (1983) used a questionnaire to ask therapists about their vacation habits. This quantitative survey had a small sample size, with only 37 participants. Another downfall to this survey was that a lot of context was missing regarding therapists’ reasons for their responses. For example, one therapist stated that s/he avoided vacations during the holidays. Although it might be assumed that the therapist is referring to the primary recognized holidays in the United States, and in the Christian faith, such as Thanksgiving and Christmas, this is not accounted for. It is unknown if the therapist is in fact only accommodating Christian and American clients, or if she/he is being more multiculturally balanced.

Webb (1983) reported a wide range of client reactions to the therapists’ vacations (i.e., anger, anxiety, depression, envy, jealousy, panic, acceptance, improved self-confidence/competence, improved problem-solving ability, decreased level of dependence on the therapist), which one would expect to be the case since no two dyads are the same. Of the 37 viable questionnaires returned, over half of the sample took between four and five weeks of vacation per year, usually split between two to three breaks, with the break during the summer being the longest. About two-thirds of the therapists responded that the longest vacation they ever took was between three and five weeks, and the notice that they gave to their clients concerning their vacations ranged between one and three months ahead of time, with one month being the most frequent response. Therapists gave varied reasons as to why they would give their clients more or

less notice, citing severity of the clients' symptoms and the length of the upcoming vacation. With the small sample size, however, very little can be drawn concerning the meaning of the frequencies. This is a limitation that Webb (1983) recognized, writing that even though the sample "is not considered representative, it serves to rectify the neglect of the topic of vacation-separations in the literature, and calls attention to the need for additional study related to the subject" (p. 133). This is a good example of the desperation of those who look to the literature for answers on this subject and are disappointed by the results.

The next study (Barchat, 1988) is an unpublished dissertation that used a quantitative approach to look at the internal representations that patients experienced while they were temporarily separated from their therapists. This study approached the subject primarily from a psychoanalytic standpoint, and discussed how the internal representations changed over time, as well as the effect that separations had on patients' representations. Although the title of this work suggested that absences would be a primary emphasis within the analysis, the focus actually revolved more around the internal representations than the absences themselves. In reality, then, this study largely examined another phenomenon that occurred during a therapy break. The break itself was a secondary theme, and the only reactions to the break that were a specific focus in the results were the affective reactions of the clients.

Barchat (1988) used a convenience sample of 67 graduate students in clinical psychology programs who were in therapy two or three days per week, and had experienced a break in therapy due to their therapist taking a vacation of at least two weeks in the previous two months. Already, we can see that the sample is not at all

representative of many clients throughout the country, as participants had a high level of education and were intimately familiar in the therapeutic process as a result of their training, a point that Barchat (1988) acknowledged. Also, for a quantitative study, the sample size appears small. The author noted that a small positive relationship was found between the amount of time a client had been in treatment with a particular therapist and the intensity of her/his response to the break. What is not accounted for in any way, however, are the therapists' actions leading up to the break, during the break, or after the break, the time of disclosure of the break to the client, or the degree of processing with the client. These therapist factors may play a large role in how the break plays out. Without taking these factors into account, the study is missing a main part of the picture, and thus the resulting analysis is limited. One finding that nevertheless could be useful for practitioners to consider is that clients who knew more about their therapists reported experiencing greater fear during the therapists' vacations.

The following study (Bush, 1989) looked at trainees taking a vacation in August before returning to their clients. Results indicated that the therapists' feelings about the upcoming vacation influenced the way in which they raised it with their clients, in terms of the timing of the announcement, as well as the way in which it was framed. For example, several therapists who had considerable anxiety surrounding her/his own upcoming absence apologized in advance for the break, but later regretted doing so, as they thought it distanced them from their clients. Additionally, extra preparation with the clients leading up to the break helped trainees maintain continuity in the therapy upon their return. Bush (1989) also added that the reunion after the break played out differently depending on the therapist's approach. Specifically, those therapists who felt more

pressure to quickly return to the point at which they left off before the break experienced more trouble in the early sessions after reconvening. Trainee's found it easier, alternatively, to work through the break at reunion when they were able to use the patients' reactions to the break as therapeutic material.

This study (Bush, 1989), however, suffers from some of the same weaknesses as the one previously discussed: It is an unpublished dissertation, its sample characteristics (i.e., trainees) may significantly affect the results, and the focus shifted during the study away from therapist absences. Bush (1989) admitted that the focus of the study shifted from its initial intention, which was to study the effects of the therapists' vacations on the therapy, to centering on the trainees' professional development, because the trainees' focus during the interviews was more on their own professional development than on their cases. With regard to the sample, Bush used a convenience sample of therapist trainees from a single training program. As a result, it is impossible to know how much the specific program affected the trainees' views, as well as the quality of their management of the situation. Also, the participants were 16 doctoral students, most of whom were in either the first or second year of their programs, which again limits the applicability of the finding beyond this specific sample.

The final study (Stein et al., 1996) is a more recent quantitative study, and the first found in a peer-reviewed journal. Stein et al. (1996) researched a more specific population, patients with borderline personality disorder, and looked at the impact of their therapists' vacations. The study consisted of 41 female inpatients whose specific target behaviors were totaled and analyzed just before, during, and just after their therapists' vacations. Stein et al. (1996) included 96 vacations in total, and a strength of the study

was that multiple treatment modalities (i.e. psychoanalytic, family, and group therapy; milieu treatment; pharmacotherapy) were studied. Specifically, target behaviors defined as acting up, self-destructive, or somatic complaints were studied three days prior to the vacation, during the absence, three days after the therapist's return, and at baseline. Stein et al. (1996) defined any behavior outside of the three-day span before and after the vacation as the patients' baseline, however, which is not necessarily an accurate assumption. The time of disclosure is another possible starting point for the process to be studied, as that may have been the first time the patients had considered their therapists taking a leave, or at least the first time the patients were made aware of the therapists' leave that was of current concern. Thus, behaviors outside of the three-day buffer may not have accurately reflected patients' baseline levels, as the patients' behaviors may have begun to change prior to the three-day span, upon disclosure.

Stein et al. (1996) found that there was less acting-up by patients during anticipation and separation periods, and more at reunion, as compared to their baseline levels. The explanation of these results offered by Stein et al. (1996) is that upon the therapist's return, the patients felt safe enough to express their anxiety and anger to the therapist, knowing that the therapists could handle the emotion, and they would not leave the patients as a result of the expression. In terms of somatic complaints, the only significant finding was that patients exhibited less of this type of complaint during the anticipation period than their baseline levels. Stein et al. (1996) also found no significant relationship between target behaviors and the length of the vacation, nor the point at which it occurred in therapy.

Stein et al. (1996) only considered the effects from a behavioral standpoint, which can be helpful, but misses other important relational factors that could have a huge effect on the outcome, such as the clients' thoughts and emotions. This is a limitation that the researchers recognized themselves, specifically noting that cognitive and affective reactions were not considered. They also conceded that only archival data were used, and as a result, no reactions were examined during sessions with the therapists, and no time was devoted to looking into what the therapists did in session with the patients. The researchers themselves stated that "clearly, more study is needed" (p. 528). Also, Stein et al. (1996) acknowledged that the vacation periods studied were relatively short in duration, ranging from 7 to 18 days, and that the patients did not have any disruptions in their daily routines other than their therapists being away. Therefore, a therapist absence, even with a similar client population, could play out very differently in an outpatient setting, or in a setting in which more change would occur for the patients as a result. It is important to note, though, that the authors stated that the findings contradict what they had heard anecdotally, which was that patients with borderline personality disorder have very strong self-destructive reactions to their therapists' vacations. This discrepancy between empirical findings and professional opinion suggests that we may not be able to trust therapists' individual, non-empirical accounts of absence effects, which again illuminates the need for more research.

Clearly, then, far more research on this topic remains to be done. The only empirical studies that were discovered during this search addressed therapist vacations (vs. other types of therapist absences), and much remains to be explored even regarding that particular type of absence. Those who have encouraged the field to examine this

topic more closely are to be commended, yet the follow-up has been scarce. With so many unanswered questions, one must ask when someone will answer these calls, dive into the “gold mine of insight” (Schafer, 2002, p. 64), and provide the field what is necessary to fill this hole.

Types of Absences

Numerous different events can lead to a therapist absence during the therapy process. Whether a therapist falls ill, a family emergency unexpectedly emerges, or the therapist simply wants to take a vacation, absences during one’s career are unavoidable. The various types of absences mentioned in the literature can be categorized, but the current study was not dependent upon this material, as a similar approach was taken to that of Barish (1980), who grouped all anticipated absences together to explore how they were managed. Vacations and maternity leave are the two most common types of breaks mentioned in the literature that allow for advanced notice, while many other types of absences can be categorized as sudden or unexpected (therapist illness, family emergency, etc.), and there is a great deal of variance between clinicians in their approaches to these absences, no matter the type (Barchat, 1988; Chiaramonte, 1986; Cullington-Roberts, 1994; McCarty, SchneiderBraus, & Goodwin, 1986; Sarnat, 1991; Siebold, 1999; Webb, 1983). As such, the current study did not concern itself with the specific cause of an absence, but looked at those that can be anticipated.

Related Concepts

After examining the literature on therapist absences, it appears that absences are addressed by clinicians who maintain a psychoanalytic perspective more than any other orientation (Barchat, 1988; Cullington-Roberts, 1994; Kohut, 1971; Langs, 1973;

McCarty et al., 1986; Mendel, 1975; Montgomery, 1985; Peck, 1961; Sable, 1992; Sarnat, 1991; Schafer, 2002; Siebold, 1999; Stein et al., 1996). Even this perspective, however, typically only touches on therapist absences in passing, and Siebold (1999) noted that even when therapist absences are discussed, the analysis is far from complete, and does not properly depict their complexity or provide any depth of analysis.

Specifically, those who wrote about absences from a psychoanalytic perspective tended to focus more on the client factors and how to approach the initial disclosure of the absence, without covering the reunion, a key aspect of the continuing process. Therefore, the main theoretical approach through which authors have looked incompletely addresses therapist absences; thus, we will need to look at some of the main concepts that are closely related to therapist absences from which the authors drew in their attempts to garner insight into the topic.

Object relations. One of the most common ways in which the literature has attempted to make sense of therapist absences is in terms of object relations (Barchat, 1988; Bush, 1989; Chiaramonte, 1986; Greenberg, 1963; Sable, 1992; Sanville, 1982; Sarnat, 1991; Schafer, 2002; Stein et al., 1996; Todd et al., 2003; Webb, 1983). This makes sense, as object relations theory is based on people's development of ways of relating to others, with separation being one of the key issues within object relations, along with attachment (Hamilton, 1989). Barchat (1988) found no significant relationship between the level of object relations and the number of therapy sessions. These results would suggest that, according to the object relations model, clients who have been with the same therapists for a longer period of time are no better or worse equipped to handle an absence by their therapists. Barchat (1988) does concede, however, that the lack of

results could have been due to the unique sample in this study, which was made up of therapists who were clients in therapy themselves. With a shortage of studies, based on the writer's search, looking at the actual effect of object relations on therapist absences, we are left with the opinions and experiences of those who wrote on the subject of object relations theoretically. It is worth noting, however, that object relations appears to be a concept closely tied to therapist absences, at least when examining the ways in which the limited literature that is available attempts to explain therapist absences.

Separation. When referring to subjects that are intertwined with therapist absences, separation is a clear choice to address. After all, a break in the therapy process equates to a temporary separation between the client and the therapist (Barchat, 1988; Bush, 1989; Sable, 1992; Webb, 1983). Blanck and Blanck (1974) wrote, "the first therapeutic step in dealing with feelings about the therapist's vacation is always to ascertain what it means in terms of separation anxiety and repetition of traumatic separation in the past" (p. 181). Bush (1989) went a step further, writing that a therapist's absence can also serve to give the therapist and patient relevant information throughout the process in order to analyze how the patient reacts to and deals with separation at all stages. As the therapy relationship is a human relationship first, separation from a therapist can mimic that of an outside relationship (Glenn, 1971). Glenn (1971) stated that even when separations are temporary, the client's pride can be hurt, though the return brings with it the possibility of repair. Indeed, separation of any type can be a triggering topic, and even more so when at least one of the parties involved experiences particular trouble dealing with separation, such as patients with borderline personality disorder (Stein et al., 1996).

Attachment. Of course, separation is intimately related to attachment.

Attachment theory, and the level of attachment to the therapist, are other lenses through which authors have looked when attempting to explain the interaction between client and therapist surrounding the therapist's absence (Barchat, 1988; Bush, 1989; Chiaramonte, 1986; English, 1971; Greenberg, 1963; Hare-Mustin & Tushup, 1977; McCarty et al., 1986; Sable, 1992; Sarnat, 1991; Siebold, 1999; Stein et al., 1996; Webb, 1983). Sable (1992) explicitly put forward the idea that childhood attachment can transfer to the adult client's therapist, and can then become a prime suspect in the formation of the client's reactions toward the therapist in all aspects of the therapeutic relationship, including times when the therapist is physically absent. Although one might intuitively assume that attachment to the therapist would correlate positively with the client's ability to cope with an absence, Barchat (1988) found that clients who had been seeing the same therapist for a longer period of time reported a greater degree of anger during their therapists' absences. It is unknown, though, if in reality there was a greater degree of anger from those clients, or if their extended time with the therapists enabled them to feel more comfortable disclosing their anger, thus allowing them to work through it with their therapists, whereas the clients with less time to attach to their therapists may have been more likely to keep their feelings to themselves, and feel a greater sense of distance from the therapists as a result. Either way, it is important to keep the concept of attachment in mind when thinking about therapist absence.

Working alliance. Working alliance, which can be defined as "the quality and strength of the collaborative relationship between client and therapist in therapy" (Horvath & Bedi, 2002, p. 41) is of great relevance when thinking about therapist

absences, and is “central to the practice of counselling psychology” (Richards, 2011, p. 56). A better working alliance could conceivably help clients weather a therapist’s absence, while a similar absence could damage the relationship in a dyad with a poor working alliance. Horvath and Bedi (2002) elaborated on the alliance, describing it as a relationship “in which each participant is actively committed to their [sic] specific and appropriate responsibilities in therapy” (p. 41). It is not difficult to envision a scenario in which a client believes that the therapist has violated his/her commitment, and is not actively committed to the process, when the therapist is absent from therapy. Therefore, by this logic, even though a strong working alliance could be helpful during an absence, it does not render the relationship immune to a rupture brought on by a break in therapy on the part of the therapist. It thus makes sense to consider the working alliance when pondering therapist absences, but the state of the alliance must never be taken for granted, as, upon the therapist’s return, it could be vastly different from when he/she left. As a result, the alliance must be regarded as a fluid concept and incorporated into the bigger picture as another source of information, as well as a potentially useful tool.

Termination. Termination is another concept that is closely related to breaks during the therapeutic process (Barchat, 1988; Chiamonte, 1986; Glenn, 1971; Greenberg, 1963; Webb, 1983; Wolberg, 1988). A temporary absence during the process can shine light on how the client may potentially react to future termination, and termination literature can be drawn from to help inform management of therapist absences. Barchat (1988) wrote, “patients’ reactions to temporary separations over the course of psychotherapy provide crucial clues to their inner lives, as well as to later dynamics in termination” (p. 30). Indeed, this assertion makes logical sense, and also

provides an additional argument to the importance of developing a better understanding of therapist absences as a whole. Thus, termination literature may inform the management of therapist absences, and authors who wrote about absences often also considered their relation to termination. This literature is thus included in the relevant sections of this literature review as fortifying information.

Therapist self-disclosure. Finally, therapist self-disclosure is a concept that is acknowledged as a primary consideration in the management of therapist absences (Blanck & Blanck, 1974; Chiaramonte, 1986; Cullington-Roberts, 1994; Langs, 1973). When an absence is upcoming, or when one has passed, therapists are faced with the task of deciding how much, or how little, to disclose to the client. Also, inadvertent self-disclosures, such as a female therapist's growing belly during pregnancy, could advertise a future absence to the client, taking part of the decision out of the therapist's hands (Cullington-Roberts, 1994). The amount of disclosure is not always within therapists' control, but even when a therapist is able to control the amount of disclosure, there is little agreement on how much is appropriate, ranging from little necessary disclosure (Blanck & Blanck, 1974) to a potential variability of the level of disclosure, depending on the client (Chiaramonte, 1986). The important point to remember is that there is no research that is readily available concerning self-disclosure around therapist absences, yet disclosure is a consideration that cannot be overlooked when addressing the topic of therapist absences.

Ethical and Legal Considerations

The American Psychological Association (APA) (2010) stated in their Code of Ethics only that therapists must make "reasonable efforts for facilitating services" so that

in the case of an absence of any type, their clients are able to contact someone to seek help if needed. This is, of course, only a statement of the minimum expectations of therapists in the field, and focuses solely on problem management. This requirement only addresses the ethical standard of non-maleficence; there is no mention of attempting to step into the realm of beneficence. Such an attitude reflects a lack of understanding about the subject, and closely parallels the attitudes toward self-care that Wise et al. (2012) addressed when they discussed the focus of only surviving, instead of focusing on the positive aspect of self-care, or flourishing, asserting, “a limitation of this model is that it starts at neutral and spirals down” (p. 488). Ethically, we are obliged to maintain a minimum standard of practice. However, when a practitioner anticipates an absence on her/his behalf and finds the paucity of literature on the subject, one source he/she may very well turn to in order to gain some clarity is this very guideline, which does not guide us beyond this minimum starting point.

While the “reasonable efforts for facilitating services” is the minimal general requirement as spelled out by APA, and may well be sufficient to serve some clients, it may not provide sufficient protection for all clients. Indeed, when a therapist is forced to be absent from his/her practice, he/she is often seeing clients at all different stages of therapy, experiencing varying symptoms and symptom severities. There are a number of crisis situations that clients could face, both in advance of the absence and during the time that the therapist is absent. Some examples of crises that could arise are suicidal ideation, instances of child abuse, or intimate partner violence, just to name a few (Karakurt et al., 2014). Such crises present obvious ethical and legal considerations, as they would whether the therapist was absent or present at the time of the crisis. Karakurt

et al. spoke to these crises when occurring between sessions, offering helpful considerations and tips. They did not, disappointingly, bridge their points to address when the break is longer than the normal amount of time between sessions.

Crises are not the only times when the “minimum required” approach may be insufficient, though. To illustrate this point, Wise et al.’s (2012) viewpoint spoke to the importance of self-care and its implied relevance for therapist absences:

When we focus on surviving, we inadvertently maintain a barely good enough status quo and fixate on preventing the negative. In contrast, when we aspire to flourish, we invite a broader array of possibilities into our personal and professional lives, and we emphasize resilience-building attitudes and practices that reflect an overarching positive orientation. (p. 488)

This claim is relevant to absences, because therapists are human beings, and as such, they inevitably bring personal needs and circumstances into the therapy room, which have an effect on the therapeutic process (Blanck & Blanck, 1974; Chiamonte, 1986; Cullington-Roberts, 1994; Glenn, 1971; Langs, 1973; Siebold, 1999). Therapists must do what they can to work through clients’ reactions to their absences, but they must also manage their own feelings, which are real and should not be overlooked (Greenberg, 1963; Hare-Mustin & Tushup, 1977; Sarnat, 1991; Schafer, 2002; Webb, 1983; Weintraub, 1990). This is especially true as it relates to feelings of anxiety and guilt that can arise when they are faced with temporarily leaving their clients (Schafer, 2002). As Schafer (2002) wrote, “it is not easy to mark off where appropriate concern ends and undue anxiety and guilt begin” (p. 62). The struggle, then, is to find a balance and manage these situations when they present themselves, as opposed to attempting to cut absences out altogether, in order to maintain self-care and practice ethically over the course of one’s career.

Ethical considerations concerning absences also present themselves when alternate forms of communication are used to continue contact during a physical absence, such as using a telephone or the internet (Masi & Freedman, 2001; Weintraub, 1990). Issues could involve confidentiality, or a diminished ability for the therapist to read the client using visual or audible cues (Masi & Freedman, 2001).

Although it has already been established that there is not substantial literature addressing therapist absences, among the literature that does exist, few address the ethical or legal aspects. In fact, no other sources were found during the search process that specifically speak to the ethics involved in therapist absences.

Considerations Affecting the Break

Just as there is a multitude of components that affect the therapeutic process, a break in therapy due to a therapist absence can play out in very different ways, based on many factors. Although some of the primary elements will herein be discussed, countless unanticipated problems can come about even after the therapist and client attempt to diligently address the break ahead of time (Sanville, 1982; Sarnat, 1991). At the same time, gains in therapy can result from absences as well, and can emerge from a variety of circumstances (Chiaromonte, 1986; English, 1971; McCarty et al., 1986; Medini & Robenberg, 1974; Webb, 1983). Some of the components that alter the course of the break will now be discussed, keeping in mind that an exhaustive account is impossible, as the considerations are endless.

Therapy setting. Therapy occurs in a variety of settings. There are also multiple layers of which a setting consists. Setting can refer to the physical location, the type of practice or clinic, the population primarily served, and factors within the room in which

therapy takes place. All of these settings affect the therapy process, which means they also have an effect on an absence that occurs during that process.

In terms of practical setting, individual and group practices present different options during absences, which are largely not spelled out in the literature either. Some barriers that a clinician in solo practice must overcome if considering a substitute therapist are physical location, knowing to whom she/he would like to refer her/his clients, differing agency policies that could affect the temporary exchange, and simple convenience. These issues are largely avoided when practicing in a group practice, as colleagues are able to plan with each other as a group, and approach the therapist absence as a team (McCarty et al., 1986).

The hospital setting presents a unique system of its own. Some hospitals offer both inpatient and outpatient services, interdisciplinary teams, and long- and short-term therapy. The inpatient setting, as observed by Stein et al. (1996), offers a milieu where patients can be observed and treated by other staff when the patients' primary therapists are absent. Montgomery (1985) provided an example of another way in which a hospital can serve as a protective factor, describing a case in which a client with masochistic tendencies was able to abstain from harming herself during her therapist's absence due to her access to an open hospital setting.

University counseling centers provide another context worthy of consideration. For example, they typically operate within varying short-term time-frames, and since they normally follow the schedule of the school year, they usually have regularly scheduled periods during which they are closed to clients. Therefore, many counseling centers have scheduled and expected therapist absences built into the work year. This

format is not always preferred by clients, as Lamb and Latona (1989) noted through a case example. Nevertheless, this model of built-in breaks changes the way in which absences are approached, as the expectations are different from the outset.

Multicultural considerations. As much as cultural factors surely have an effect on the way in which a therapist's absence unfolds, the literature from which one can draw to explore the impact of culture on therapist absences is scant. One factor that could play a part in a therapist's absence is the client's socioeconomic status. For example, if a therapist is thinking about using a substitute therapist outside of his/her practice during a break, yet the client has limited transportation options, the choices may be limited. The client's socioeconomic status would also likely affect the insurance that s/he would be able to secure, which could further limit substitute options during an extended break. Another consideration, particularly if the therapist's absence is a result of a vacation, is how the particular absence affects the client's perception of the therapist and their relationship. If a client is not able to take a vacation due to finances, the therapist may need to address any negative feelings that could arise toward the therapist as a result. At the same time, however, the therapist must not assume that any ill will would automatically come from the client, and if the therapist assumes jealousy, it could be very insulting to the client.

An additional consideration is the availability of services for the client while the therapist is gone. This could mean the potential for a substitute therapist, for another clinician to be made available in times of crisis, or even a hospital within reach for the client. Such challenges may increase for therapists practicing in rural areas, where there

might only be one therapist in a town, or even an entire county. As a result, further precautions must be taken in order to ensure the safety of the clients during an absence.

Language is another consideration. There is a growing population within the United States of families whose native language is one other than English. When a diversity of language is mixed into the therapy process, it can further complicate matters, whether or not the therapist speaks the same language as the client (Softas-Nall, Cardona, & Barritt, 2015). When a client whose native language is not English is taking part in therapy and her/his therapist announces that he/she will not be available for the next three weeks, what is the client to think? If s/he is at a stage where s/he needs to see someone else in the meantime to help him/her through the time off, then does the therapist know of another competent practitioner who speaks the client's native tongue? If not, what are the options? Does the client know how to cope in a time of crisis without speaking the language of those whom he/she would need to contact? Of course, the answers to these questions depend on many factors, and many are answered on a case-by-case basis. This is yet another example, though, of a subtopic under the umbrella of therapist absences that needs to be better understood through research in order to best serve a population that already must deal with robust barriers.

Another cultural aspect for the professional to be aware of is the timing of the absence. In the previously described study, Webb (1983) wrote that one therapist participant noted that he/she avoided taking vacations over the holidays, but the holidays to which he/she was referring were not mentioned. Most likely, the therapist was referring to holidays in the same way that they were mentioned in the Hare-Mustin and Tushup (1977) article, which assumed that the primary majority culture's holidays, such

as Christmas, are the most important to consider. This is an example of a situation where the therapist likely thinks that she/he is trying to serve her/his clients, putting the clients ahead of her/himself. For a large proportion of the clients, this assumption is probably true. What about the clients who do not celebrate the same holidays as the therapist in question, though? Not only would the therapist not be affording the same luxury to all of his/her clients, but s/he could simultaneously be sending the message to her/his cultural minority clients that the holidays that they celebrate are not as important. This could introduce differing layers of complexity, depending on the client and his/her history. If this is an area in which the client has felt marginalized by society as well, the relationship with the therapist could be damaged, limiting the therapist in the work that he/she would be able to do with the client thereafter. Such an indiscretion could also lead to the client dropping out of therapy without seeking another therapist due to a loss of faith in the field as a whole.

Client factors. When considering client factors in conjunction with any therapy event, including therapist absences, relevant diagnoses and client struggles must be considered (Barish, 1980; Blanck & Blanck, 1974; Chiamonte, 1986; Greenberg, 1963; Lamb & Latona, 1989; McCarty et al., 1986; Sanville, 1982; Sarnat, 1991; Siebold, 1999; Simon, 1992; Stein et al., 1996). Diagnoses, actually, are one of the few specific areas that have been examined empirically with therapist absences, though only one study (Stein et al., 1996) and one non-empirical piece (Lamb & Latona, 1989) focused on this topic, with each specifically targeting patients with borderline personality disorder.

Stein et al.'s (1996) previously addressed study found that patients in the sample were actually less likely to act out leading up to their therapists' vacations, which was

contrary to what they had hypothesized based on what they described as collective commentary. Lamb and Latona (1989) used a case example to illustrate exactly what Stein et al. (1996) presented as popular belief. Lamb and Latona (1989) described a case in which a patient with borderline personality disorder exhibited a number of acting-out behaviors prior to, and during, the therapist's vacation (i.e., demanding more sessions, contacting the patient's previous therapist to disclose suicidal ideation). Although Lamb and Latona describe what seems to be the common perception, Stein's study yielded quite different findings, again attesting to the need for more research.

Blanck and Blanck (1974) believed that patient factors directly influence the way in which the therapist should address her/his absence with the patient ahead of time:

The seriously depressed patient should be able to reach the therapist. The psychotic patient needs to know at least that the therapist still exists on earth. For the borderline structure, it is often sufficient to mention the geographical area where the therapist will be; it helps him tolerate the therapist's absence if he can refer to a map or to his knowledge of geography to reinforce his uncertain and shaky knowledge that the therapist exists in absentia. (p. 182)

Although these could be valid suggestions, there is no mention as to how these conclusions were reached, so one must assume that the authors are drawing from their own clinical experience in order to make these assertions. This appears to be another example of the fact that there is an abundance of opinions about how to handle a therapist's absence, and a paucity of informative, empirical literature, a balance that needs to shift. It can always be helpful to learn from those with experience and knowledge in a field; however, a new therapist's training should not rely primarily on opinions, whether from a book, the trainee's supervisor, or his/her own experience. Such examples are appropriate when used as supplementary material, yet these appear to be the

main types of sources that can be found when looking into client factors related to therapist absences.

Chiaramonte (1986), drawing also from personal experience, suggested that when developing a treatment plan with a patient to span the absence, patient input should be taken into consideration to varying degrees, as the patient's judgement may be strongly affected by her/his emotions over being left by the therapist. Chiaramonte (1986) also agreed that patients could have various reactions to therapists' absences, and that these reactions must be taken into consideration by the therapists when deciding what to do with their clients during the time they will be away. Chiaramonte (1986) posed that patients with fewer avenues for coping, a lesser ability to deal with situations within themselves, and those with diagnoses that impair their functioning more severely would be more likely to require a regularly scheduled appointment with another therapist during the span of their existing therapists' absences.

Therapy with children often plays out quite differently than that with adults, yet not much was found when attempting to discover how these two client populations might differ during a therapist absence. There is a common idea that childhood experiences with separation can affect how a therapist absence is dealt with by clients (Barchat, 1988; Chiaramonte, 1986; Greenberg, 1963; Sable, 1992; Stein et al., 1996; Webb, 1983; Weintraub, 1990). When attempting to compare child clients to adults during absences, though, not much is offered. One difference that may affect the break is that child outpatient clients may have others who have more extensive direct contact with the therapists on their behalf than adult clients, such as their guardians or caregivers. Weintraub (1990) provided an example, in that her child client's mother called the

therapist during the first week of the absence to inform the therapist that the client's symptoms had significantly worsened. This phone call altered the course of the therapist's physical absence, in that weekly telephone sessions were started as a result. These unanticipated phone sessions helped the client to gain relief while the therapist was out of the office. One could envision the same process playing out with adult clients as well, though it may be less frequent, as they would need to make the call for themselves.

Overall, then, client factors indeed influence the response to a therapist's absence. More empirical evidence is needed, though, to better understand how to best manage such absences and protect the client's welfare.

Therapist factors. Many of the therapist's own factors come into play, as well, when thinking about the therapist's absence from therapy with his/her clients (Webb, 1983). As previously discussed, Bush (1989) postulated that a therapist's attitude toward her/his own break can affect how the break is experienced by the client. Another salient therapist factor involves the type of absence. If the therapist's upcoming absence is due to a pregnancy, Chiaramonte (1986) posited that the patient may find it more difficult to let his/her pregnant therapist know that he/she is upset about the absence, due to guilt or shame about having such feelings in the first place. He/she could also worry that if he/she disclosed these feelings of discontent to the pregnant therapist, the therapist might not want to resume therapy with her/him after the break. Thus, a therapist's absence can bring out insecurities in patients, which could be informative and beneficial if dealt with properly, but harmful if mishandled or if not explored at all. Chiaramonte (1986) also noted that the therapist's personal stance toward self-disclosure makes a difference for how the break will be approached, and that this stance then interacts with the therapist's

assessment of each client's specific needs, culminating in a final decision for each client about the amount to disclose.

Schafer (2002) suggested that negative consequences could arise if the therapist decides to avoid any absences on his/her part, thus sending the message to the patient that she/he is not able to take care of her/himself. Schafer (2002) also pointed out that the therapist may perceive the patient as having more difficulty with the absence than the reality, as a result of projecting the therapist's own feelings or worries onto the patient.

Clearly, this is only a small taste of the possible therapist factors that can affect the client before, during, and after an absence. This is what is contained in the literature, though, as of now, pointing again to the overall theme of minimal research regarding therapist absences.

Time in therapy. Even after many of the more concrete, constant factors are accounted for, such as therapy setting, client presenting issues and diagnoses, and therapist factors, time can present itself as a significant element of its own, and influence the course and outcome of the absence. When talking about time regarding an absence from therapy, one must consider several features of time. Webb (1983), for example, discussed the timing of a therapist absence as critical regarding client readiness for the break. Webb (1983) argued that clients who are not ready for a break could regress, whereas clients who are prepared could even benefit and grow from the therapist's absence. As we know, client readiness for such events does not solely depend on what the client initially brings into the therapy room. The point at which the client and therapist are in their therapeutic process could be a large contributing factor to the client's readiness as well, which is a testament to the important role timing can play in a

therapeutic break. Webb (1983) additionally posited, though, that it is not only the point in the process at which the therapist absence occurs that matters, but also that the length of the break itself is important to contemplate, as it can influence how the client responds, a position seconded by Siebold (1999).

Vacations are obviously not the only type of therapist absence, however, and alternative motives for breaks in therapy can bring with them variable break durations, such as that which was described by Weintraub (1990), when complications during pregnancy forced the therapist to take extended time off to remain on bedrest. Also, as Siebold (1999) and Lamb and Latona (1989) pointed out, the duration of therapy with the individual client at the time of the break, and the overall plan for how long the therapy will last, can be significant factors. For example, if a therapist sees a client in long-term therapy, the probability increases that the client will need to endure multiple absences on the part of the therapist (Siebold, 1999). This is not necessarily a negative to the client, however. In fact, the client is given an opportunity to learn from each break in therapy, and can then work with the therapist on being able to better handle, or even benefit from, subsequent therapist absences, as well as separation or loss in the client's life outside of therapy. Timing, then, is an important consideration in therapist absences, one that again warrants further empirical examination.

Reactions

Many factors have been discussed thus far that could influence the outcome of a therapist's absence. What we must not lose sight of in the process, however, is the actual outcome itself. Our focus, hence, will now shift from the influential factors to the observed outcomes. How *do* therapist absences affect clients? How do clients typically

react to their therapist's absence, and how does the therapist experience all of this? These are important questions to ask, and we will now look to the literature to attempt to gain some insight into possible answers.

Client reactions. One can envision a variety of client reactions in response to his/her therapist's imminent absence, ranging from aversive, to indifferent, to feelings of relief. What has been put forth in the literature has reflected this variation to some degree, though popular opinions reflected in non-empirical writings have leaned very heavily in the negative direction. The problem, again, is that although client reactions to therapist absences are mentioned throughout the literature, "exclusive attention to this aspect of the treatment process is lacking" (Barish, 1980, p. 5). Specifically, one of the most common effects on clients that authors have cited concerning looming therapist absences has been an increase in anxiety (Barchat, 1988; Barish, 1980; Blanck & Blanck, 1974; Chiamonte, 1986; Cullington-Roberts, 1994; Glenn, 1971; Sable, 1992; Stein et al., 1996; Webb, 1983). Blanck and Blanck (1974) argued that an anxiety reaction is so common that it should be the first avenue explored with the client. Other negative reactions can be exhibited as well, though, such as narcissistic injury, aggression, feelings of abandonment, or suicidal ideation, and the patient's reaction can be largely dependent upon his/her personality characteristics and history (Barish, 1980; Blanck & Blanck, 1974; Cullington-Roberts, 1994; English, 1971; Hare-Mustin & Tushup, 1977; Lamb & Latona, 1989; Montgomery, 1985; Sanville, 1982; Siebold, 1999; Stein et al., 1996; Webb, 1983). Information about a client's response to separation could also come from changes in behavior, such as acting out (Greenberg, 1963; Lamb & Latona, 1989; Langs, 1973; Sanville, 1982; Schafer, 2002; Siebold, 1999; Stein et al., 1996), or patients may

suddenly bring dreams into the therapy room (Barish, 1980; Langs, 1973; Peck, 1961; Stein et al., 1996).

There is leeway in Blanck and Blanck's (1974) view, though, in that they suggest that the initial reaction need not be the lasting effect on the client, and that instead, the discussion between therapist and client regarding the absence will powerfully influence clients' reactions to the absence. This stance was backed by Weintraub (1990), citing a specific example with a child client in which her absence turned from an acute negative into a positive. Barish (1980) also contended that the client's initial reaction, whether negative or positive, is not indicative of the final outcome. Instead, Barish (1980) stated that the reactions spanning multiple therapist absences could act as a good "indicator of change" (p. 15), as the therapist can assess whether the client's reactions have improved, remained the same, or regressed with each absence. Of course, Barish (1980) was addressing the topic from a standpoint of long-term therapy, while not all therapists have the luxury of being able to follow their clients' reactions over time.

Instead, a patient could have a seemingly innocuous initial reaction, while her/his true feelings may not emerge until just before the break, if at all (Chiaramonte, 1986). Adding to that, Chiaramonte (1986) noted that some clients tend to devalue their therapy, inaccurately describe an improvement in symptoms as the absence draws nearer, seek other sources of support, report that they are ready for termination, or cease to show up at all. These reactions could be their defenses at play, and is an area worthy of addressing. Hare-Mustin and Tushup (1977) pointed out, though, that the break can allow the client to realize that he/she is able to live without the therapist, which could be the actual reason for an abrupt termination, and should not necessarily be seen as a failure on the part of

the therapist. Furthermore, the client's reaction to the absence could be a telling sign of how she/he reacted to separations in the past, thus affecting the overall outcome positively by providing the therapist with insight that may have otherwise remained hidden (Greenberg, 1963).

Therapist reactions. As much as some therapists try to limit the effects that their personal reactions, or their countertransference, have on the therapeutic process, therapists are still human beings. When they are forced to tell their clients that they will need to step away for a period of time, they are engaging first in a human process, and then in a therapy process (Glenn, 1971). Indeed, just as the client experiences a loss, stress and anxiety, or guilt, even if temporary, so does the therapist (Barchat, 1988; Cullington-Roberts, 1994; Greenberg, 1963; Hare-Mustin & Tushup, 1977; Sarnat, 1991; Schafer, 2002; Siebold, 1999; Webb, 1983). If a crisis has spurred the need for the absence, the circumstances can even be overwhelming for the therapist (Karakurt et al., 2014). Therefore, therapists have internal reactions to their absences that affect their actions in the therapy room to differing degrees (Glenn, 1971). These reactions can also be a useful source of information as to what is going on in the room between therapist and client, and may also provide insight into what the patient is experiencing at the same time (Barish, 1980; Glenn, 1971). There are far fewer instances of therapist reactions being mentioned in the literature than those of clients, and almost none with these reactions as a central focus.

One empirical work (Bush, 1989) found that some therapists felt a sense of responsibility to get the work back on track after the break, since it was not the clients' wish to take the pause. That added pressure made the next sessions more difficult for the

therapists. There was also a sense of worry among the therapists that their clients would terminate prematurely due to the length of the break, a finding in Webb's (1983) survey as well. At the same time, the trainees in Bush's (1989) sample thought that the break helped them to grow as therapists, and gave them information that they would not have procured otherwise. Concerning the reunions, Bush (1989) found that the therapists had a better awareness of their own feelings about the work with their clients after the break, and some also felt more connected to their clients, with the belief that this was sparked by the time apart. At the same time, some therapists felt less connected to their clients after the break, and experienced difficulties thereafter in their work with these clients. Bush (1989) found that the therapists who were more confident and comfortable with their therapeutic skills tended to experience more positive effects of the break, and those who were less confident as therapists felt more negative effects. Interestingly, regardless of their attributes, most therapists said that a few sessions were needed after the break for them to feel "settled in their work with their patients" (p. 77). Bush (1989) recognized that these findings must be taken with a grain of salt, though, given the participants' trainee status. Also, all participants in the study came from the same training program, which could have a significant effect on the results. More research is needed to see if some of these results are consistently found across training programs, as well as across experience levels.

Other factors can complicate the therapist's feelings about his/her own absences, such as the type of absence or the patient response. What sense, for example, would a therapist make of realizing that he/she wanted his/her patient to miss him/her while he/she was away? That is an example given by English (1971), describing a young

therapist's reaction to a patient who said that he/she was glad that the therapist was going to go on a vacation. Thus, therapists need to be aware of how their human emotions and reactions might affect the processing of the absence, such as the natural tendency to avoid discussing feelings of pain or guilt (Greenberg, 1963). A pregnancy-related absence, for instance, could introduce a number of complications, and increase the guilt felt by the therapist (Sarnat, 1991). With the whirlwind that a pregnancy can be for the mother on its own, it is important that the pregnant therapist be as aware as possible of her own feelings and reactions, both surrounding the pregnancy and the imminent absence.

Suggestions from the Literature

Pre-absence. Barish (1980) suggested that there are three different types of sessions that occur prior to an anticipated break in therapy. The first type comes about when the patient is defensive just before the break, and is basically biding her/his time until the absence so she/he feels more comfortable and less exposed. This type of session is one in which not much happens therapeutically. The next type of session just before the break sees deeper content emerge, such as dreams or old memories, and involves a large amount of therapeutic work. This session is seen as a positive by both parties. The last type of session falls somewhere in between the first two, where the client appears to be doing some work, but the feeling at the end is that not a lot was accomplished. The last type of session remains more surface level than the second, but does not feel as constrained as the first. We must keep in mind, though, that Barish (1980) developed these ideas through readings, combined with personal experience; little empirical data exists to support these descriptions.

Continuing to address therapist absences that can be foreseen, there are differing schools of thought. Blanck and Blanck (1974) and Langs (1973) believed that the most appropriate disclosure of one's absence to the client, other than a vacation, involves few details, a stance not uniformly embraced by other authors (Chiaramonte, 1986; Cullington-Roberts, 1994; Weintraub, 1990). For example, if the therapist's reason for taking an absence is due to pregnancy, her control over how much information is given to the client is immediately reduced, as the physical changes during pregnancy are typically evident after a period of time. Also, Cullington-Roberts (1994) cited a case example that displayed potential harm to clients when a therapist fell ill and minimal information was disclosed to the clients, leaving them wondering what was going on and wondering if they had hurt the therapist in some way. The therapist in that example felt that more factual information should have been disclosed to the clients, helping to ease their minds and lessen the ambiguity. The amount of disclosure, surprisingly, is not one that is frequently addressed in the sources that discuss therapist absences. In fact, considering the frequency that therapists initiate breaks in therapy, there is surprisingly little literature detailing how one can best manage the situation (Webb, 1983).

There appears to be a common belief, however, that an absence should be disclosed to the client well in advance, particularly if the therapist is able to foresee it with ample time, with suggestions ranging from several weeks to several months (Barish, 1980; Blanck & Blanck, 1974; Bush, 1989; Chiaramonte, 1986; English, 1971; Greenberg, 1963; Hare-Mustin & Tushup, 1977; Lamb & Latona, 1989; Sarnat, 1991; Simon, 1992; Webb, 1983). The reasoning behind the advanced disclosure is so the client has enough time to work through her/his emotions about the break with the therapist, so a

plan can be developed with which all involved are comfortable, and so the break can become a part of the overall process instead of an isolated event. Hare-Mustin and Tushup (1977) provided specific topics to address with the client when discussing a coming absence. They wrote that it could be helpful to attempt to predict, in collaboration with the client, specific problems that could arise during the break, and then work through these problems in-session. The client can then draw upon this work as a template during the break, asking him/herself what his/her therapist would say about a problem when it comes up, and therefore feeling less alone and more capable of handling a wider variety of situations on her/his own. This collaboration between patient and therapist also helps the patient to feel more like an active participant in the break instead of having to experience it passively and helplessly (Stein et al., 1996).

English (1971) suggested that the therapist talk to her/his patients about the possibility of the patient lining up her/his vacation with the therapist's, so a minimal amount of time is forfeited. This suggestion could cause problems, however, particularly depending upon the population served. Bringing up such a topic and making the assumption that the client will take a vacation could highlight the different socioeconomic statuses and amount of privilege between the client and therapist. It could also show that the therapist is oblivious and insensitive to this disparity, which could alienate the client, hindering the relationship and the work. It also communicates an overblown sense of self-importance on the part of the therapist, suggesting that the patient can and should make his/her plans around the therapist's schedule, and that the patient is helpless without the therapist.

Blanck and Blanck (1974) suggested that the therapist let the patient know explicitly that she/he is not specifically leaving the patient her/himself, so the patient does not think that her/his therapist needs a break from him/her. They proposed that the therapist should then turn his/her focus to interpreting the patient's separation anxiety and other adverse reactions explicitly tied to the therapist's upcoming absence. Webb (1983) added that the therapist should be sensitive and direct when addressing these feelings surrounding separation, while Glenn (1971) noted that these emotions can also be explored in a way that helps the client gain a better understanding of how she/he copes when she/he loses someone who is close to her/him in life outside of therapy. Also, while the therapist remains as a gentle presence to welcome the client's expression of feelings, it can help to use immediacy to pay special attention to the relational factors that are going on in the room leading up to the separation (Ward, 1984). It appears that the therapist framing the break in a negative light in her/his own mind can get in the way of the work with the client, clouding his/her judgment, distancing her/him from the process, and ultimately negatively affecting how the client views the time off (Bush, 1989). Webb (1983) added that the therapist could instead broach the topic of the upcoming absence as a time of recuperation for both individuals in order to frame it in a more positive light. Another possible helpful recommendation is to reassure the client that the absence is only temporary, as he/she might fear that it will become permanent even if it was not brought up as such (Siebold, 1999).

During the absence. During the actual absence, there is typically a time of less direct therapeutic activity on the part of the therapist. By now, if pre-planned, she/he has decided with the client which route will be taken over the course of the break, and the

therapist's active role resumes upon return. If the client has not terminated, and will indeed be returning to therapy when the therapist is again available, Chiaramonte (1986) noted two options: There can be a therapeutic hiatus, or the client can be transferred to another therapist on a temporary basis. Chiaramonte (1986) stated that the decision as to what the therapist decides to do should be based on the level of current symptoms that the client is experiencing leading up to the break, his/her ability to cope, and his/her level of object relations, where a substitute would be used for those clients perceived to be less able to survive on their own. If a substitute is pushed on a client who is opposed to the idea, however, the therapist could send the message that she/he does not have confidence in the client, which could set her/him back and hurt the relationship (Chiaramonte, 1986). Lamb and Latona (1989) stated that the decision to use a substitute therapist or not should be made with the client, citing an individual example of a client in a university counseling center diagnosed with borderline personality disorder. If a substitute therapist is either forced on a client, or conversely, not offered, the client may not receive the level of necessary care while his/her primary therapist is unavailable. The substitute therapist is an option noted by several authors who chose to address the topic of therapist absence (Chiaramonte, 1986; Lamb & Latona, 1989; McCarty et al., 1986; Sarnat, 1991; Simon, 1992; Webb, 1983). We will therefore speak to the substitute therapist as a main form of activity during the break, and explore what is suggested when this route is taken.

The substitute therapist. Using a substitute therapist during a therapist's absence is an option that can play out differently, depending on the context (Chiaramonte, 1986; Lamb & Latona, 1989; McCarty et al., 1986; Sarnat, 1991; Simon, 1992; Webb, 1983). The general feeling is that clients seen by a substitute during another therapist's absence

are very capable of continuing to make gains, and that a substitute can be seen on a regular basis, intermittently, or simply be presented as an option on an as needed basis (Chiaramonte, 1986; Lamb & Latona, 1989; McCarty et al., 1986).

Using another therapist to cover the time that one is away, however, can be stressful for the therapists and the clients (Chiaramonte, 1986). To overcome some of the stressors, Chiaramonte (1986) and Webb (1983) suggested that the primary therapist should try to set in stone the specific dates that he/she will leave and return. If the leave spans a significant amount of time, the therapist could work with his/her agency, if that option exists, to hire someone to fill in for him/her while she/he is gone; another option would be to work in a team format, where the rest of the staff at the agency covers for the therapist who is away and then continues to be involved in a supervisory manner upon the return of the therapist (Chiaramonte, 1986; McCarty et al., 1986; Simon, 1992).

Yet another situation that must be considered in the transitions both to and from the substitute is the client's attachment level to the two therapists (Chiaramonte, 1986; Lamb & Latona, 1989; McCarty et al., 1986; Sarnat, 1991; Simon, 1992). A difficulty that could arise, depending on the amount of time for which a therapist is away, among other factors, is that the clients may become attached to the substitute, or they might not be willing to go through another switch at the end of the break, which could make transfer back to the original therapist difficult, or even unjustifiable. The trouble with transferring back could also come from resistance on the part of the substitute therapist. To avoid these scenarios, the interim therapist should try to keep her/his role, which is to act as a bridge, in mind throughout the process, and structure her/his sessions in a way that helps the clients to disengage at the end of the break (Chiaramonte, 1986; Lamb &

Latona, 1989; McCarty et al., 1986; Sarnat, 1991; Simon, 1992). Suggestions for how to facilitate this disengagement while still being helpful and productive were not found in the literature, however, besides the claim that supervision can be helpful throughout this process. Also, Sarnat (1991) contended that this could be a difficult line for the interim therapist to walk, and that it is more complicated than we are led to believe based on articles that suggest that route, particularly if the absence is extended. For example, Sarnat (1991) argued that if the temporary therapist maintains distance from the client during a longer period of time, she/he could contribute to the client feeling even more abandoned and alone in the interim. Another option presented to smooth this transition is that the two therapists could have a joint session with the client before the break, as well as upon the return of the original therapist (McCarty et al., 1986). Although it could be helpful, this would not necessarily be the best option with all clients, as some could find this intimidating or confusing, disrupting the intimate, safe, one-on-one session-type to which they are accustomed.

There is a continuum of options regarding the use of a substitute therapist, though, and seeing an interim therapist on a regular basis during the absence is only one option (Chiaromonte, 1986; Lamb & Latona, 1989). Another therapist can also be seen intermittently if that is found to be appropriate, or she/he can be used on an as needed basis. For some clients, it can be enough of a comfort to simply know that someone is available if needed while their primary therapist is away. If the substitute is one that is seen more regularly, however, the therapist should initially do as she/he normally would in the beginning of therapy, and attempt to establish a relationship with the client. If he/she jumps into the work too quickly, the client may feel exposed or violated, knowing

that the substitute was told a lot of information about the client from someone other than the client, or from reading it in his/her chart (Chiaramonte, 1986).

Instead, it is thought that the substitute should begin by bringing the immediate real situation into the room, and talk about the temporary transfer with the client, paying attention to her/his reactions, feelings, and concerns (Chiaramonte, 1986; Simon, 1992). This idea was also expressed by Lamb and Latona (1989), when they described that in their case example, the client felt the need to initially talk to the substitute about the primary therapist before moving onto other subject matter. This option, however necessary, can bring up anxieties of professional exposure and criticism in the original therapist, and such anxieties should be discussed ahead of time, if possible, with the incoming colleague (Simon, 1992). The substitute, during this time, should pay attention to potential nuances in the client's assertions, as the client may attempt to tell the substitute facts that were not disclosed to the primary therapist, in order to indirectly send a message to the main therapist through the substitute (Lamb & Latona, 1989). Chiaramonte (1986) believed that the interim therapist should then turn his/her focus to what he/she can accomplish with the client in the short time they have together, and that the goals should be realistic and attainable. If attempting to be too ambitious, it could alienate the client, and actually hinder the work during the break. If the therapist does not try to overstep their boundaries, and his/her approach is appropriate in a supportive, time-limited way, she/he can maximize the benefits in the time that she/he has with the client. Upon return, the original therapist should review the substitute's report, as well as speak with the client about her/his experience with the substitute therapist before moving onto

other material (Lamb & Latona, 1989; Sarnat, 1991). Lamb and Latona (1989) also suggest that the substitute's report should be reviewed with the client.

Post-absence. The time when the therapist returns and the interruption ends is an important point in the therapeutic work (Bush, 1989). No therapist and client dyads will have the exact same separation process play out, as everyone reacts differently to separation, and no two relationships are identical at the time of separation or reunion (Sanville, 1982). A main finding and suggestion for the therapist upon returning is that the focus should first be on the patient's experience of the time apart (Barish, 1980; Bush, 1989). Focusing after the fact on the time during the break instead of trying to move past it was found by Bush (1989) to help turn the absence into a positive, and to also help the overall work, bringing it to a deeper level than before the absence. An example of one way in which an absence can be used as a tool is when a therapist has multiple absences during a therapeutic relationship with a client. He/she could potentially use the absences as a measuring stick and use that diagnostically (Barish, 1980; Wolberg, 1988). Instead of seeing the break as an obstruction of the work, absences could be conceptualized as a part of the therapeutic process (Bush, 1989; Glenn, 1971). The client should be asked how he/she was during the break and where he/she thinks he/she is now compared to before the absence.

Lamb and Latona (1989) suggested tackling the first session back with a largely unstructured approach, conveying neutrality and openness in order to help the patient feel comfortable enough to give an accurate description of her/his experience. The client might indeed return in a worsened state, though it does not mean that the break will be a hindrance to the work. The reunion after a therapist's absence, when the experience itself

is addressed, can highlight maladaptive patterns that mirror those in the patient's life, which can then be worked through with the therapist in order to model a different attachment style (Siebold, 1999; Stein et al., 1996).

Training

As noted repeatedly, literature on therapist absences is severely lacking. Moreover, amongst the sources that were found in this search, there was almost no mention of training or training techniques related to therapist absences, nor even how to begin to approach the topic. Only a few manuals were even uncovered in the search that actually addressed therapist absences at all, within which very little attention was given to the topic, and it was instead generally addressed in passing (Blanck & Blanck, 1974; Kohut, 1971; Langs, 1973; Wolberg, 1988). Stein et al. (1996) asserted that the main culprit for the lack of training around this topic is the lack of literature. They stated that appropriate interventions for such absences cannot be designed until a solid empirical understanding is cultivated. In addition, Siebold (1999) suggested that the lack of literature is due to the past belief that therapy was a one-person process, and thus therapist effects were not adequately addressed. Furthermore, Ward (1984) asserted that training has historically focused more on "microcounseling" (p. 21) skills than on bigger-picture issues or events, such as termination or therapist absences. While those microskills are obviously of great importance during training, trainees must also be taught to understand the major processes that go on during therapy, which include therapist absences.

Stein et al. (1996) stated that trainees typically gain some insight into potential patient reactions to separation informally from their supervisors and professors, but that

they tend to be described “the way combat veterans describe a battle” (p. 514), typically hearing the most extreme or traumatic experiences. Stein et al. (1996) argue that when this is the main lens through which trainees are introduced to the effects of their own absences, it would be expected that they would anticipate future instances when they would need to take a leave with anxiety. If the main message being sent to trainees and young professionals is one of fear and anxiety regarding their inevitable absences, they may well struggle to manage such events effectively.

Conclusions and the Current Study

In summary, the topic of therapist anticipated or planned absences is expansive, encompassing a variety of circumstances such as vacations, sabbaticals, emergencies, or illnesses. Such absences inevitably introduce the human aspect of the therapist into the therapeutic process. Once a therapist decides to be absent from her/his practice, s/he must decide how much to disclose to the client about the details of her/his absence, and the extent of the contact the client can have with the therapist during the absence. Such decisions could also change depending on the clients involved. A multitude of factors could affect the break, including the physical setting and the type of therapy conducted, the timing of the break, client and therapist factors, and multicultural considerations. All of these aspects can lead to a wide range of reactions, elicited in both the client and the therapist. Some authors have offered recommendations for dealing with the issues that arise before, during, and after a therapist’s absence. Although the harm-reduction stance set by APA as a minimum standard is essential, much may be lost if the therapist does not attempt to move beyond that position and into the realm of using the absence as a helpful tool in the therapeutic process.

Clearly, however, we need more research that focuses specifically on therapist absences (Barchat, 1988; Barish, 1980; Bush, 1989; Chiamonte, 1986; Cullington-Roberts, 1994; Kohut, 1971; Langs, 1973; Sable, 1992; Sanville, 1982; Sarnat, 1991; Schafer, 2002; Siebold, 1999; Stein et al., 1996; Ward, 1984; Webb, 1983; Wolberg, 1988). This project sought, then, to increase our understanding of this phenomenon by investigating interruptions in the therapeutic process caused by anticipated therapist absences. I chose to examine absences that are anticipated so that all three stages (before, during, and after) could be explored. A Consensual Qualitative Research design (CQR) (Hill, Thompson, & Williams, 1997; Hill et al., 2005; Hill, 2012) was used to allow the researchers to inductively explore the phenomenon in depth, as we currently know so little. The semi-structured interview protocol lends itself to consistency across cases in the topics addressed. This study will hopefully provide a building block for future studies in this area.

III. Method

Participants

Ten participants took part in the current study. Although recommendations by Hill (2012) call for 12 to 15 participants in order to obtain satisfactory saturation of the findings, there is some flexibility in the sample size for researchers to proceed as appropriate. In the current study, a sample size of 10 participants was found to sufficiently represent the population sought, and extra participants were deemed unnecessary. Since the primary investigator (PI) conducted all interviews, it became apparent during data collection that trends were emerging in the data. Additionally, it did not appear that two extra cases would significantly add to the findings by contributing novel information. Combined with the significant recruitment difficulty, a sample size of 10 was judged to be sufficient for analysis.

Participation criteria. Participants needed to be clinicians licensed at either the master's or doctoral level in a mental health discipline, with a minimum of two years of experience post-licensure to create a well-defined sample of participants who could speak to their experiences over time. The minimum experience needed to participate was originally five years, but due to the mentioned recruitment woes, the threshold was lowered to two years. This determination still ensured that all participants would have multiple years of experience post-licensure, but would considerably widen the recruitment options. In addition, at least 50% of their professional duties had to have been devoted to psychotherapy practice, as the aim was to target participants who are primarily practitioners. Participants must have been able to discuss a time when they were absent from their therapy practice while they were actively seeing clients. At the time of the

absence, participants needed to have already seen the specific client they discussed for a minimum of four weeks and a minimum of four sessions, in order to allow for the therapist to process through the upcoming absence with the client, as well as establish rapport. Participants also had to have seen the client for at least one session after the absence, so participants could speak to the absence both before and after the actual event. To ensure that the absence in question was a significant diversion from the norm, it had to have been one to six weeks in duration, during which the participants missed at least one session with the clients whom they chose to discuss. Originally, the requirements dictated that the absence needed to last at least two weeks, and there had to have been at least two sessions missed. Again due to the aforementioned recruitment difficulties and feedback received from those who initially declined to participate, it was deemed necessary to allow shorter absences (i.e., less than two weeks) to be discussed. It was also determined that this change would not hurt the integrity of the study since a two-week absence may resemble a 10-day absence more than it would a six-week absence. In addition, participants must have known about the absence at least two weeks in advance, to ensure enough time to process the absence with the client. The clients who experienced the absences needed to be at least 18 years of age and seen as outpatients in individual psychotherapy within the last two years, to again ensure a well-defined sample. Finally, although clients discussed in the examples could have sought professional help during the absence, there could not have been an appointment scheduled with a substitute therapist prior to the absence discussed.

Participant demographics. All participants were female, with a mean age of 39.3 years (range = 30-62, SD = 9.3). Participants identified as Caucasian/White (n=7),

Asian (n=1), Indian (n=1), and multi-racial (n=1). Professional licensure included Psychologist (n=8), Clinical Social Worker (n=2), Clinical Professional Counselor (n=1), and Marriage and Family Counselor (n=1). Please note that there are more license disclosures than participants due to some participants holding multiple licenses. Participants had practiced for a mean of 7.9 years (range = 2-26, SD = 7.5). Participants identified a range of theoretical orientations: Cognitive Behavioral (n=5), Psychodynamic (n=2), Bowenian (n=1), Eclectic (n=1), Existential (n=1), Feminist (n=1), Humanistic (n=1), Integrative (n=1), Interpersonal (n=1), Multicultural (n=1), and Systems (n=1). Participants reported being absent from their practice for at least two weeks a mean of 1.3 times per year.

Client Demographics

Clients discussed as examples reportedly identified as female (n=7), male (n=2), and transgender (n=1), with a mean estimated age of 50.5 (range = 28.5-75, SD = 13.1). Race/Ethnicity included Caucasian/White (n=6), African American (n=2), and not identified (n=2).

Absence Demographics

Absences discussed as specific examples were split between vacation (n=6) and surgery/medical leave (n=4). Four participants discussed their first absence with the specific client, while six had already experienced an absence with the client prior to the one chosen as the example.

Research Team

The primary research team was comprised of the PI and two additional primary team members. The PI is a 32-year-old Caucasian male in the fourth year of a doctoral

program in counseling psychology at Marquette University. One of the other primary team members is a 31-year-old Caucasian female postdoctoral fellow, completing her fellowship at a university counseling center. The other primary team member is a 40-year-old Caucasian female, and is a professor in the PI's doctoral program at Marquette University. The auditor is the PI's advisor and dissertation chair, who is a 57-year-old Caucasian female and a professor in the PI's doctoral program. All team members had previous experience with the CQR methodology.

Biases. In accordance with Hill's (2012) recommendations, the research team discussed their biases prior to data analysis. Biases were first reflected upon and recorded by each team member individually. Each member's reflections were then sent to the rest of the team, and were discussed as a team via a conference call meeting.

During the discussion, team members recognized feelings of apprehension and guilt leading up to their own absences, though the feelings changed in intensity depending on the clinical setting and specific client needs. Team members also noted processing upcoming absences with clients, and altering the approach to fit each client's needs. Members described having minimal formal training regarding therapist absences, and expected participants to convey a similar lack of training. It was expected that participants would experience distressing feelings prior to their absences. Additionally, team members thought that participants would change their approach based on their clients' needs and would attempt to plan appropriately without having a set of guidelines to follow.

Design and Procedures

The study focused on absences that are anticipated so that all three stages (before, during, and after) could be explored. A consensual qualitative research design (CQR) (Hill, 2012) was used to allow the researchers to inductively investigate the phenomenon in depth, and allow for an analysis of rich data, thus gaining insight into a topic about which we currently know little. The semi-structured interview protocol lends itself to consistency across cases in the topics addressed. Furthermore, the consensual nature of the analysis process inherently lends itself to trustworthiness. Primary team members must all agree throughout the process that they are remaining as true to the data as possible, and act as checks to each other that inferences are not being made. An additional filter is placed on the process through the auditor, typically someone who is highly experienced in the CQR process and cannot succumb to groupthink, since the auditor is not present during team meetings.

The initial protocol was formed by the PI, following recommendations by Hill (2012). It was then revised with the PI's advisor, who, as noted, was also the auditor for the study. The protocol was then further revised with the dissertation committee prior to pilot interviews. Two pilot interviews were then conducted by the PI, with the protocol being adjusted based on the PI's and interviewees' feedback. Following Hill's (2012) design, the primary research team, along with the auditor, discussed their biases related to therapist absences.

Opening questions were designed to develop rapport with participants, introduce them to the topic, and gather some general thoughts they had about therapist absences as a whole. These questions were broad and are not emotionally-charged. Following the opening section, participants were then asked about a specific example of a time when

they were absent during the therapy process. Participants were then asked specific follow-up questions detailing before, during, and after the absence in question, as well as their thoughts about the overall experience. The interview finished with a closing section, where participants were asked about some final thoughts regarding the subject matter, and questions related to the interview itself.

Recruitment

Participants were recruited through a combination of advertising on national and international listservs, alumni listservs, professional groups and forums, physical flyers at local clinics, requests made through the PI's professional contacts, and snowball sampling.

Once interested and qualified participants were identified, they were sent the demographic form (Appendix A), informed consent form (Appendix B), and interview protocol (Appendix C). Participants filled out and returned the informed consent form and the demographic form to the PI. The PI then contacted the participant, scheduled an interview time, and proceeded with the interview. Interviews took place over the telephone, and were recorded by an audio recording device. Recordings were then transcribed. Once prepared, the transcripts were ready for data analysis.

Confidentiality was maintained throughout the process. Participants were given a code which was used to identify their transcript. Quotations were used, but never attached to any names. All identifying information was removed from the transcripts. Prior to attempting to publish the manuscript, all participants will be given the opportunity to review the manuscript to ensure that their confidentiality has been maintained. In

addition, the standard procedures/precautions were taken regarding the guarding/destroying of materials as delineated by the PI's governing IRB.

Data Analysis

Once interviews were transcribed, the primary team began meeting on a weekly basis to carry out the CQR analysis (Hill, 2012) by first organizing the data into domains. The team first domained a chosen transcript together, noting overarching topics that emerged from the data. Once these topics, or domains, were developed based on the initial transcript, the team then examined a second transcript together, to see if the domains applied and to refine them as necessary. As only minor changes were made to the domain list based on the second transcript, the team then moved on to the rest of the transcripts, organizing the data from the interviews into domains, with the primary team meeting to discuss their domaining and resolve any disagreements until consensus was reached.

Once all transcripts were organized into domains, the primary team then developed the core ideas from the data. Essentially, the team members condensed the data into their own words, capturing the essence of the data within their corresponding domains, while staying as close to the participants' words as possible. The PI developed the initial core ideas for all transcripts, and the team then met to discuss changes to the core ideas and reach consensus. The cored transcripts were then sent to the auditor, whose comments were reviewed and incorporated by the team as a whole.

Finally, all core ideas across all cases in a given domain were placed together to facilitate the cross-analysis stage. In this stage, the primary team reviewed the core ideas within each domain and identified themes or categories in the core ideas across cases.

Category labels indicate the number of cases that reflect that category: If a specific category contains all cases or all but one case, it was given the label, “General;” if a category contained more than half of the cases, but did not meet the “General” cutoff, it was designated as “Typical;” if a given category contained at least two cases, but no more than half of the cases, it was labeled, “Variant.” Each team member was assigned multiple domains to cross-analyze, with the amount of material being approximately equal across team members. The process then followed a protocol similar to the previous two stages, where each domain was cross-analyzed by the assigned team member, and the team then reconvened to discuss any disagreements and potential changes until consensus was reached. Each cross-analyzed domain was then sent to the auditor for review, whose comments were incorporated, and the results were finalized.

IV. Results

Findings are presented in three main sections: contextual findings, specific event findings, and concluding findings. Frequencies within categories will be described as general (i.e., all, or all but one case), typical (i.e., more than half of the cases until the general cutoff), and variant (i.e., at least two cases, until the typical cutoff).

Abbreviations used in the table and headings are as follows: P (participant), C (client), PT (psychotherapy), and Rx (relationship).

Training Received Regarding T Absences

In the first stage of the interview, participants were asked about any training they had received regarding how to manage therapist absences. Participants generally had received either minimal or no formal training or supervision on the topic. One participant stated that he received “definitely nothing formal,” while another received “absolutely none.” Those who reported minimal training described the topic being briefly broached in supervision leading up to an absence, or earning a quick mention in an ethics class. To a variant degree, participants independently sought their own information and guidance regarding therapist absences. This self-guided search involved speaking with colleagues who had previously gone through a similar experience.

Emotions/Thoughts Regarding T Absences

Participants were also asked to describe the overall (i.e., not tied to a specific client) emotions and thoughts they experience regarding their absences. Generally, participants reported feeling distressing emotions leading up to their absences. More specifically, they generally reported both worry and anxiety. Participants described worrying more about higher-risk clients (i.e., “suicidal or psychotic”), as well as clients

in certain settings with access to fewer resources (i.e., private practice). Depicting another distressing emotion, participants variably described feeling guilty about taking an absence because they feared that the absence would have a negative impact on a client or that a client would think that the therapist does not care about them.

Not all of the thoughts or feelings experienced by participants are distressing, however. Participants variably experienced excitement or relief leading up to or during their absences, which appeared to be brought on by the prospect of having a break from work. Additionally, participants variably reported gaining comfort with their own absences. A few participants, for example, noted experiencing more absence-related anxiety and guilt earlier in their careers than they did at the time of the interview. Finally, participants variably reported thinking about and executing a plan for their absences. As an illustration, they gave extra thought to higher-risk clients and wondered how a given absence would play out.

General Approach to Absences

Still in the opening stage of the interview, participants were asked to describe the general approach they take for breaks in the therapy process due to their own absence. Generally, participants noted creating a plan for their clients leading up to their absences. Though the degree to which participants planned differed based on a number of factors, they all reported developing some type of plan they deemed appropriate for the client and the absence. For instance, one participant described arranging for coverage with her colleagues, developing emergency contingencies, letting clients know about the absence, and working with her supervisor “to get things squared away.” Another participant stated that for clients with fewer resources, she talks with them about behavioral interventions

to distract them or take their minds off a situation to cope on their own. Participants also generally described changing their approach to the absence based on client characteristics. One participant, for instance, reported informing different clients of an upcoming absence earlier or later depending on the expected impact that knowing about the absence would have on a given client, while another described giving substantial consideration to her approach if the client has a personality disorder or “attachment types of issues.” Participants also gave examples of altering their approach based on severity of the client’s presenting issue, the client’s support system, and the typical length of time between sessions. Generally, participants also directly discussed their absences with clients. For instance, one participant reported trying to be as open as possible with clients regarding her absences, while another stated she thought that having a discussion about the absence, including some general details, can be rapport-building with some clients. Lastly, participants variably reported keeping their absences to a minimum. For instance, participants noted not wanting to disrupt the flow of therapy with clients, and wanting to avoid being absent if at all possible.

Next, participants were asked to speak about a specific time when they were absent between one and six weeks with a particular adult, outpatient client within the past two years. They were asked to describe their experience related to the absence with the chosen client in depth, with questions focused on the three stages of the absence (i.e., before, during, and after), as well as the overall experience and effects. Results are described below.

Table 1. Contextual (i.e., not specific event) Findings

Training Received Regarding T Absences

Minimal or no formal training/supervision	General
Independently sought information/guidance	Variant

Emotions/Thoughts Regarding T Absences

Distressing emotions	General
Worry/Anxiety	General
Guilt	Variant
Excitement/relief	Variant
P gained comfort with experience	Variant
P thinks about/executes plan for absence	Variant

General Approach to Absences

P creates plan for Cs	General
P changes approach based on C characteristics	General
P directly discusses absence with Cs	General
P keeps absences to a minimum	Variant

PT Relationship

Participants generally described the therapeutic relationship as strong, trusting, and good. One participant described the relationship as “trust-filled,” while another reported they “got along famously.” Participants variantly reported that the relationship was difficult at first, though improved over time, with one participant stating it took her client a long time to consider that the world could be looked at in a different way.

What P Did During Absence

Participants variantly reported recuperating from surgery or having a health concern during the absence, and also variantly engaged in international travel (i.e., a vacation outside the United States).

What C Did During Absence

Participants variantly stated that they knew of nothing significant occurring with their client during the absence (i.e., the client did not use any emergency services).

Participants also variably reported, however, that they knew their clients made use of the break by working on their therapy goals during the absence. One participant reported that their client completed an entire journal book the participant had given the client for homework. Finally, participants variably reported that the client attempted to contact the participant during the absence (i.e., called and left a message).

P's Pre-absence Thoughts/Feelings about Absence

Participants typically reported positive feelings, broken down into two more descriptive subcategories. To a variant degree, participants reported being confident or unconcerned. One participant reported being “absolutely confident” regarding her client during the absence; similarly, another participant did not think the absence would be “life changing,” because the participant was confident the client would be able to utilize the coping skills developed through the therapy process. Additionally, participants variably reported positive feelings leading into the absence because they looked forward to the absence. One participant noted feeling excited to “get away,” while another noted not wanting to “have [the client] on [the participant’s] brain.”

Though less frequently, participants did variably report negative thoughts and feelings prior to their absence. More specifically, they were variably worried or nervous before the absence. The worries centered around concerns about the client’s safety (i.e., due to past suicidal thoughts), as well as potential damage to the therapeutic relationship. Participants also variably felt guilty (i.e., because the absence was for personal reasons), and variably feared early termination by the client as a result of the absence (i.e., “I wasn’t 100% sure [the client] was going to come back”).

Variantly, participants reported feeling mixed emotions as their absence approached. One participant described having “every ‘I’ dotted and every ‘T’ crossed,” but still felt somewhat anxious because the participant would be leaving the country and would be unavailable if any issues arose. Lastly, participants variantly discussed deciding whether or not to disclose details about their absence, and if so, how to make such a disclosure. More specifically, one participant talked about considering the client’s personal factors in such decisions (i.e., discussing a family vacation with a client with relationship issues), while another discussed the need to ensure that any absence-related disclosure did not shift the focus onto the participant.

P’s Thoughts/Feelings about Absence During Absence

Participants both variantly reported either no or minimal thoughts or feelings regarding the specific client during the absence, and also variantly reported worrying about the effects of their absence. With regard to the former a participant noted, “mind is not at all here...not in my clinical work, it’s not even in my life here whatsoever;” with regard to the latter, one participant stated she was a “nervous wreck” while away.

P’s Post-absence Thoughts/Feelings about Absence

Few participants identified any thoughts or feelings in this domain, but of those who did, they variantly reported being happy to be back from their break. One participant, as an illustration, reported being happy to get back to the regular routine, while another was happy to see her specific client’s face at the end of the absence.

C’s Pre-absence Thoughts/Feelings about Absence

To parallel the line of questioning into the therapists’ internal worlds, we also wanted to get a sense of their perception of the clients’ thoughts and feelings around the

absence. Typically, clients seemed unconcerned about the absence. For instance, participants described not noticing any reactions at all from their specified client, while others stated their client was not only understanding, but encouraging prior to the absence. Variantly, however, clients appeared anxious or worried about the absence. (i.e., “everybody leaves me, everybody abandons me”). Finally, clients’ responses variantly changed over time. One participant described her client feeling anxiety at first, but later expressed confidence just before the absence that the client would be fine and knew what to do.

C’s Thoughts/Feelings about Absence During Absence

Although we hoped to garner a sense of what the client was thinking or feeling during the absence, too few participants described their client’s experience during the break to yield any themes. As a result, no categories emerged from this domain.

C’s Post-absence Thoughts/Feelings about Absence

Similar difficulty arose when participants described what they thought their client thought or felt about the absence after it was over, though one category did emerge. Here, clients variantly were happy or relieved the absence was over (i.e., one client was really happy in the first session post-absence, which was very different from the client’s usual demeanor).

P’s Approach to Absence (prior)

A major focus of this study was to explore how therapists managed their absences. Generally, participants reported planning for the absence directly with the client. Examples of the planning with the client involved discussing emergency contacts, resources the client could contact during the absence if the client thought s/he needed to

meet with another professional for any reason, homework assigned to the client during the absence, and scheduling the first session following the absence. Additionally, participants typically reported discussing their plan for the client with other providers. In some cases, the participant already had regular meetings with other clinicians at the same clinic and worked planning for the client during the absence into those regular discussions; whereas other participants sought out providers who would be involved in coverage during the absence to make sure they were in the loop or to consult regarding the plan.

When discussing their approach to the last session prior to the absence, participants typically reviewed the client's growth, the work they had done, and the tools the client had acquired in the final session before the absence. One participant described discussing these aspects in the final session to help the client continue to grow during the absence, and another did so to aid the client in how to problem-solve difficult situations on his/her own during the absence. Participants also variably reminded their clients about the absence in the final session (i.e., discussed with the client again that the participant would be absent), tried to end the last session on a positive note (i.e., not "diving into deep issues"), or approached the last session like any other session (i.e., "I certainly didn't approach it any differently because I felt so comfortable that he knew what was going on, like he knew the plan so far in advance").

The final group of categories that surfaced from these data involved disclosures to the client regarding the absence. Two variant categories emerged here: Some participants remained vague or cautious with their client in disclosing about the absence, and some disclosed details of the absence to the client without concern. One participant, for

example, reported disclosing general details about the absence “without giving too much away,” while another participant described being fairly open regarding what the client wanted to know about the absence details.

P’s Approach to First Session Post-absence

Participants generally “caught up” with their clients during the first session back. One participant reported asking the client, “How was your time,” another described taking a generally lighthearted approach to the session, and another checked in about specific issues such as the client’s anxiety and memory. Next, participants variantly described the first session back as “business as usual,” or a typical session, with one participant noting there did not seem to be any disruption at all. Participants also variantly shared some general details about their absence with the client in their first session back. One participant disclosed that she had spent some time with her parents, but did not disclose any more specific details, while another gave the client some general details about the surgery the participant had undergone during the break, because the participant had been gone a significant amount of time. Finally, participants variantly described assessing the plan of care with their client in the first session back. For instance, participants specifically mentioned discussing with their client how they would like to proceed in therapy going forward.

C’s Reaction to P’s Return

Variantly, there was no significant change in interactions on the part of the client when the participant returned from the absence. As an illustration, participants described their clients’ reactions as natural, friendly, normal, and “par for the course.” Clients did variantly comment on the absence upon the participant’s return. One client commented

on the participant's tan from the sun, another joked about the participant being away, and a third asked the participant how the surgery had gone. Variantly, some clients post-absence were more talkative, had a brighter affect than usual, and were happy to see the participant, while others were variantly distressed upon return. For example, one client had a big smile on his/her face, while another who does not typically show a lot of emotion cried in her first session back.

Factors Complicating Absence for P

When thinking about peripheral factors that played a role in how the absence was experienced by participants, three variant categories captured complications affecting the absence. First, participants reported experiencing personal struggles around the time of the absence, such as sick family members, physical pain, or a growing sense of burnout. Participants also described facing logistical struggles or stresses around the time of the absence, such as needing to make complicated preparations leading up to the absence. Finally, participants reported the absence being complicated by the client's presenting concerns, such as a client with borderline personality disorder with whom one participant felt the need to be "delicate."

Factors Facilitating Absence for P

Continuing to consider factors that affected participants' experience of the absence, two variant facilitating factors emerged. First, the client was improving before the absence, either due to a strengthened support system or more effective medication management (i.e., a client was doing better at work). Second, clients could relate to what the participant was doing during the absence (i.e., one client had already experienced a surgery, while another had previously gone on a cruise).

Impact of Absence on P

After considering a number of specific details of the absence, as reported above, participants described the overall impact the absence. First, they typically noted a positive impact on themselves. As specific subcategories here, they variantly felt refreshed or relieved. One participant, as an illustration, stated that the positive feeling resulted from “a break from the responsibility of everybody else’s problems.” Another called the absence “much needed relief.” Participants also variantly noted gaining comfort for future absences due to the experience of the described absence. For instance, they felt more relaxed leading up to a subsequent absence because they had a better sense of what to expect. Participants also variantly stated that they gained perspective or insight about the client or therapy, (i.e., seeing that the client was able to survive without the participant, or having some space to consider the case from a different perspective).

Not all effects reported on participants were beneficial, though. Variantly, participants reported having an increased workload and level of stress both before and after the absence. For example, they had difficulty tying up loose ends before the absence and immersing themselves back into their work just after the absence ended.

Impact of Absence on C

Typically, clients gained resilience or recognized their own resilience via the absence. One participant, for example, noted that the absence gave the client a chance to see that he could make it through the day fine without the participant as a “security blanket.” Another participant described needing to terminate with her client to begin another job, and stated the experience of the absence helped the client successfully transfer to another therapist, which the participant did not believe would have been

possible prior to the absence. Though seen at a lesser frequency, participants also variantly stated the absence caused the client distress (i.e., due to abandonment and trust issues).

Impact of Absence on PT/Rx

Variantly, the absence had either no effect on the therapy or relationship or had a positive effect. As an example, one participant did not “think it missed a beat.”

Impact of Absence on Future Absences

Participants variantly stated either that the specific absence had no impact on future absences, or that it variantly gave the participant a better sense of how to plan for future absences. Participants reporting the latter occurrence described having more knowledge of what to expect in future absences, which better informed participants’ therapy decisions leading up to absences and decreased stress; regarding the former, one participant stated it “really didn’t” have an impact.

Impact of Absence Overall

When taking everything into consideration, all participants viewed the absence to have a positive impact. For instance, one participant stated the absence was positive for the outcome of the therapy, while another reported the participant’s positive relationship with the client helped the absence to be a helpful challenge.

What P Would Do Differently Regarding Absence

Typically, participants stated that they would do nothing differently. One participant stated she would not change anything, while another did not think there was anything else that she could have done. Variantly, participants stated they would discuss the absence more with the client than they did in the specific case, both before and after

the absence itself. For instance, one participant wondered what it would be like to discuss what the absence was like for the client in terms of the relationship following the absence. Finally, participants variantly stated that they would take a longer absence. As an illustration, one participant stated she would have taken the full six weeks of her maternity leave and try not to worry about it, but did not because the participant did not “remember learning about how to deal with long absences.”

Table 2. Specific Event Findings

PT Relationship

Strong/trusting/good relationship	General
Difficult at first	Variant

What P Did During Absence

Recuperated from surgery/health concern	Variant
Traveled internationally	Variant

What C Did During Absence

Nothing significant	Variant
Worked on PT goals	Variant
Attempted to contact P	Variant

P's Pre-absence Thoughts/Feelings about Absence

Positive	Typical
P mainly confident/unconcerned	Variant
P was looking forward to the absence	Variant
Negative	Variant
P mainly worried/nervous	Variant
P felt guilty	Variant
P feared early termination by C	Variant
Mixed emotions	Variant
P considered how/whether to disclose absence details	Variant

P's Thoughts/Feelings about Absence During Absence

None/Minimal	Variant
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Worry Variant

P's Post-absence Thoughts/Feelings about Absence

P was happy to be back Variant

C's Pre-absence Thoughts/Feelings about Absence

C not concerned about the absence Typical
 Anxious/worried Variant
 C's response changed over time Variant

C's Thoughts/Feelings about Absence During Absence

Other Variant

C's Post-absence Thoughts/Feelings about Absence

C was happy/relieved the absence was over Variant

P's Approach to Absence (prior)

Planning related to absence
 P planned for the absence with C General
 P discussed plan for C with other providers Typical
 Approach to last session pre-absence
 Reviewed growth/work/tools with C in last session Typical
 P reminded C about absence in last session Variant
 P tried to end last session on a positive note Variant
 P approached last session like any other session Variant
 Disclosure to C regarding absence
 P remained vague/cautious with C in disclosure about absence Variant
 P disclosed absence details to C without concern Variant

P's Approach to First Session Post-absence

P and C "caught up" after absence General
 First session back was "business as usual"/typical session Variant
 P shared some general details about P's absence Variant
 P and C assessed plan of care Variant

C's Reaction to P's Return

No significant change in interactions Variant
 C commented on absence Variant
 C more talkative/brighter affect than usual/happy to see P Variant

C distressed upon return Variant

Factors Complicating Absence for P

P was experiencing personal struggles Variant

P faced logistical struggles/stresses Variant

P's absence was complicated by C's presenting concerns Variant

Factors Facilitating Absence for P

C was improving before the absence Variant

C could relate to what P was doing during the absence Variant

Impact of Absence on P

Positive Typical

 P felt refreshed/relieved Variant

 P gained comfort for future absences Variant

 P gained perspective/insight about C/PT Variant

Increased workload/stress pre-/post-absence Variant

Impact of Absence on C

C gained/recognized own resilience Typical

Caused C distress Variant

Impact of Absence on PT/Rx

No effect Variant

Positive Variant

Impact of Absence on Future Absences

No impact Variant

Gave P better sense of how to plan for future absences Variant

Impact of Absence Overall

Positive General

What P Would Do Differently Regarding Absence

Nothing Typical

Discuss absence more with C Variant

Take longer absence Variant

Advice to Other Ts

Three variant categories emerged here. First, participants reported that absences are important and necessary for therapists. One participant, for example, stated that therapists should “absolutely should take breaks from therapy” both for their own health and to increase their clients’ independence. Participants also stated that it is important for the client and the therapist to have a plan for the absence, with some participants adding the plan should be made as soon as possible, and that the therapist should have an initial plan of her/his own for emergency coverage before broaching the subject with the client. Lastly, participants stated that therapists should know that clients will be okay during absences. One participant, for instance, specifically urged new therapists to realize that clients are stronger and more capable than therapists might think.

Why Participated

Generally, participants wanted to be helpful to the primary investigator and to the field (i.e., to help a fellow colleague, and completion of school is really important). Variantly, they participated simply because they fit criteria and were interested in the topic (i.e., interesting topic).

Experience of Interview

Generally, participants found the interview to be positive and thought-provoking (i.e., enjoyable, thought-provoking).

Table 3. Concluding Findings

Advice to Other Ts

Absences are important/necessary for T	Variant
Important (for C and T) to have a plan for absence	Variant

Cs will be okay during absences

Variant

Why Participated

Wanted to be helpful to PI/field
Fit criteria/interested in topic

General
Variant

Experience of Interview

Positive/thought-provoking

General

V. Discussion

In an attempt to create a clear roadmap, I begin by examining the contextual findings related to participants' reported preparation or training regarding absences, their general thoughts and feelings about their absences, and their general approaches to such absences. Next, I discuss the findings regarding specific examples in order of the three main stages of the absence: before, during, and after. Finally, I discuss the overall outcomes therapists encountered as a result of their absence, their concluding thoughts, and an acknowledgement of the study's limitations, as well as its implications for training, practice, and research.

Contextual Findings

Training received regarding therapist absences. The findings in this study mirrored that which has been asserted in previous literature: Participants largely attempted to manage their absences with little-to-no guidance provided throughout their training. Although some therapists may have had to improvise when situations arose for which they had not been trained (e.g., participant had not been given any guidance on how to approach own absences), others took initiative by looking to the extant literature, as well as trusted colleagues, to find the answers to questions that arose. Inevitably, therapists will encounter unforeseen circumstances that demand that they think on their feet. Anticipated absences from therapy, the focus of the current study, however, are not unforeseen, and thus need not fall into the category of reactionary scenarios. Instead, they call for the creation of general guidelines.

There are multiple theories regarding why therapist absences have not been included into standard training curricula. The broadest, most obvious reason, is that the

topic as a whole has scarcely been explored empirically (Barchat, 1988; Barish, 1980; Bush, 1989; Chiaramonte, 1986; Cullington-Roberts, 1994; Kohut, 1971; Langs, 1973; Sable, 1992; Sanville, 1982; Sarnat, 1991; Schafer, 2002; Siebold, 1999; Stein, Corter, & Hull, 1996; Ward, 1984; Webb, 1983; Wolberg, 1988). Without a solid foundation of research, it is difficult for those involved in providing training to offer reputable recommendations about how to manage a therapy absence. Other plausible responses to this question are that “microcounseling” (Ward, 1984, p. 21) skills are more heavily trained, and that therapist effects have not been a focus of training in the past (Siebold, 1999). Therapists often seek not to allow their personal lives to affect their professional lives, and ultimately their clients, in a negative way. Thus, illuminating the fact that therapists’ personalities, and their personal lives, including absences, may indeed affect therapy may be a difficult acknowledgement. Regardless of the reason, this study found that the observed gap in training remains.

Therapists’ thoughts and feelings about their absences. Therapists appear to experience a wide range of thoughts and feelings in anticipation of their absences. Distressing emotions were most often endorsed, with worry or anxiety being most prevalent, followed by guilt. Indeed, this finding seems to be consistent over time, as therapist distress has been previously reported to closely accompany approaching absences (Barchat, 1988; Cullington-Roberts, 1994; Greenberg, 1963; Hare-Mustin & Tushup, 1977; Sarnat, 1991; Schafer, 2002; Siebold, 1999; Webb, 1983). For some participants, the distress was significant enough to lead them to significantly reduce their absences (e.g., avoid being absent if at all possible), a somewhat ironic approach, given

that some participants noted they would have taken a longer break after seeing that the specific absence they described actually yielded more positive outcomes than expected.

Most therapists choose to enter the field at least partially because they want to help others. Once they start seeing clients, they form unique, trusting relationships with each client. It can be easy, particularly when surrounded by other caretaker types, for therapists to assume an inordinate amount of responsibility for their clients' emotions and wellbeing. When the clients' presenting problems are added to the mix (e.g., relationship, trust, attachment issues; depression, anxiety, suicidality), it is easy to imagine why therapists would worry about doing something that could disrupt the therapy process and ultimately result in potentially harmful results for the client and/or others. An important aspect that can easily be lost, though, when therapists are catastrophizing, is that their clients have all survived before meeting them, and that the goal is for them to be able to survive again in the future without them. Furthermore, examination of specific absence examples (see below) proved participants' concerns to be largely unfounded, supporting this assertion.

Not all participants in the study had only negative views of absences, though. Some therapists were able to cut through the anxiety of the repercussions of potential absences, and described feeling excited or relieved about their imminent breaks. Experience seemed to play a sizeable role in how therapists felt about and dealt with their absences. Specifically, therapists reported being more comfortable with their own absences as they progressed in the profession. This is unsurprising on multiple fronts. Besides the general expectation that a more seasoned therapist will be more confident in her/his own skills, a steeper learning curve can be expected in areas in which one did not

receive training at the outset. It is difficult for most to be confident in their skills in an area in which they were not trained. As a result, each repetition appears to improve therapists' absence self-efficacy.

Therapists' approach to absences. The literature suggests that absences should be disclosed to the client with as much notice as possible (Barish, 1980; Blanck & Blanck, 1974; Bush, 1989; Chiaramonte, 1986; English, 1971; Greenberg, 1963; Hare-Mustin & Tushup, 1977; Lamb & Latona, 1989; Sarnat, 1991; Simon, 1992; Webb, 1983) so that therapist and client have sufficient time to develop a plan for the absence, a finding that was universally endorsed by participants in the current study. Vital parts of many plans included emergency contacts, homework, and preparing for specific foreseeable stressors, though specific plans are often altered to fit the specific client, as seen both in this study and in the literature (Mustin & Tushup, 1977).

It is important to again note, as stated above, that even though therapists appear to be aware of steps to take in preparation for an absence, some participants in this study described keeping their absences to a minimum as a primary strategy. Perhaps a contributing factor to therapists' overall absence-related anxiety is that they were less able to consider detailed plans in which they could be confident when describing them in the abstract versus when describing a specific absence with a specific client. Of note, no participants addressed their plan upon returning from absences when asked about their general approach, which suggests that they did not look beyond the absence itself and picture a successful result. Instead, their focus remained primarily on the detail-oriented, anxiety-producing pre-absence time when it was easy to consider everything that could go wrong.

Specific Event Findings

Pre-absence.

Therapists' thoughts and feelings about their absences. Interestingly, when participants described a specific time when they were absent, they less often associated feelings of distress with the experience leading up to their absence. They still endorsed feeling worried, nervous, and guilty, but they did not report such feelings with the same frequency as when they described absences in the abstract. One explanation for such a discrepancy may be that therapists see absences more negatively by focusing on the abandonment of their clients when they think of them as a hypothetical, whereas their actual experiences of absences from their own clients do not play out as negatively as they fear. Thus, therapists' anxieties may more readily manifest in the abstract rather than in the lived experience with their own clients.

Participants also feared that clients might terminate early due to the therapist's absence, a finding echoed in the literature (Bush, 1989; Webb, 1983). Although early termination may occur at times, these fears proved to be unfounded, as the participants' clients returned to therapy following the break. It is unclear whether therapists who fear early termination take greater precaution with the identified clients, which helps reduce the likelihood of early termination, or whether there was just less cause for concern than anticipated. Either way, therapists appeared to fear the impact of their upcoming absences more than they needed to in hindsight.

Although distress appeared dominant during therapists' preparations for hypothetical absences, and was present to an extent leading to their specific absence examples, positive emotions were more frequently endorsed than negative ones in

describing their actual absences. In this study, in fact, some participants reported looking forward to the absence, and some described being confident and unconcerned. Although the current study did not look to directly connect these two feelings, Bush (1989) found such a connection. The confidence reported by therapists could come from a number of sources (e.g., confidence in their own skills, client presenting concerns, surrounding support). Thus, the less distress a therapist associates with her/his absence, the more she/he may be able to take a true break.

The peripheral factors found in this study that complicated (i.e., client presenting problems, participants' personal struggles, logistical stressors) and facilitated (i.e., client improvement prior to the absence, client relating to the participant's upcoming experience) participants' experiences of their absences, combined with other questions (i.e., how to discuss the absence with the client), only depict a sample of possible considerations when managing an absence, and certainly speak to why therapists reported a mixture of absence-related emotions. Although participants largely reported having confidence in the therapeutic relationship with the client about whom they spoke, the absence-related worries were not wholly erased for some participants. It seems that a strong relationship may give some therapists confidence leading into their absences, while others may fear hurting the relationship they worked so hard to build by temporarily leaving the client via an absence.

Clients' thoughts and feelings about therapist absences. While anxiety, or overall distressing emotions, are the most widely reported client experience of therapist absences within a limited literature base (Barchat, 1988; Barish, 1980; Blanck & Blanck, 1974; Chiaramonte, 1986; Cullington-Roberts, 1994; English, 1971; Glenn, 1971; Hare-

Mustin & Tushup, 1977; Lamb & Latona, 1989; Montgomery, 1985; Sable, 1992; Sanville, 1982; Siebold, 1999; Stein et al., 1996; Webb, 1983), the majority of therapist participants in the current study did not report any anxiety or worry when describing their clients' emotional state leading up to the absence; to the contrary, most reported their clients not being concerned about the absence. Similarly, Stein et al. (1996) described how trainees often expect the worst possible outcomes regarding leaving their clients for any amount of time in the middle of the therapy process, expectations that may not actually come to fruition. It is no wonder that trainees and young professionals more often have negative views of taking a break of any type due to their sense of responsibility to their clients. As has been asserted above, trainees and young professionals often lack the training and the experiences to realize that these negative popular beliefs may be unfounded. Participants in the current study, however, were more seasoned therapists, and thus had the time to experience multiple absences and observe their clients' unharmed reactions.

Therapists' approach to absences. Although a sizeable difference was seen between participants' thoughts and feelings when considering absences in the abstract compared to their actual experiences, the same was not found to be true about their approach: Therapists were consistent when they described their approach to absences in the abstract (i.e., contextual findings, above) and when they described absences with specific clients. Every participant, for instance, described making a plan with her/his client, and all but one reported conferring with or informing other providers regarding the plan. The overall goal appeared to be to ensure that everyone was on the same page (i.e.,

therapist, client, staff), and that there was a plan about which both the therapist and client could feel comfortable.

Although all participants discussed the absence plan with their clients, the level of detail disclosed may depend on the therapist's style and level of comfort, as well as client factors (Chiaramonte, 1986). The findings here echoed this sentiment, with some participants disclosing rather openly about the absence when asked, while others described were cautious and remained vague about what the absence involved. It should be noted, though, that of those who were less disclosing regarding the absence, some later acknowledged that they would have discussed the absence more fully with their clients.

Specific recommendations about the approach to the final session before a therapist's absence are scarce in the literature, which is not surprising, given the minute body of work available. In this study, participants described attempting to end therapy before the break in a way that gave clients a sense of confidence in their own abilities, and generally left them on as positive a note as possible. After reminding the client about the absence in case it slipped her/his mind, an important detail in the last session was acknowledging the client's growth and her/his improved coping skills. Since the client will not have the therapist as a safety net during the absence, it is important that she/he feels confident in his/her own skills, and also that the therapy process can continue to work even with an extended time between meetings. The goal is for the client to approach the absence with an active rather than a passive mindset (Stein et al., 1996). In that vein, it appears that therapists more often kept the last session light, or as more of a review, and did not delve into new or deep material. As previously stated, though, each therapist-client dyad is different, and some participants approached the last session before the

break like any other session, whether because of their perception that the client could handle it, the type of therapy being conducted, or other factors signaling no need for a change. This, again, suggests that although more solid guidelines are needed to prepare therapists for absences, the guidelines eventually provided will need to include great flexibility.

During absence. During a therapist absence, the primary options are to have the client take a break from therapy, or to make arrangements for him/her to see a substitute therapist in the interim (Chiaramonte, 1986). Much of the literature that addresses the time during the absence is devoted to the latter option (Chiaramonte, 1986; Lamb & Latona, 1989; McCarty et al., 1986; Sarnat, 1991; Simon, 1992; Webb, 1983). As a reminder, this study focused on cases in which a substitute therapist was not utilized.

Whether engaging in international travel or recovering from surgery or other health concerns, participants were largely not available to clients during the absence. Some participants noted that this lack of availability elicited worry, while others barely thought about their clients during their time away. As will be discussed later, the latter findings could be the result of participants choosing cases to discuss that were positive examples of how the process can play out, or examples of clients for whom they had fewer concerns.

Indeed, participants in this study did not report significant client incidents during the break. The clients they discussed did not have scheduled appointments with substitute therapists, nor did they feel the need to reach out to their emergency contacts, thus validating the therapists' lack of anxiety regarding the clients' wellbeing. Clients appeared most often to use the break to work on their goals set in therapy, which means

they were able to follow through with the plans developed with their therapists before the absence. Even the few clients who attempted to contact their therapist during the absence did not experience noticeable consequences when their attempts were unsuccessful.

Post-absence. Therapists appeared to put greater emphasis on preparing for the absence than they did any other stage. As a result, there are not as much data regarding events and reactions immediately following the absence, nor is there much to consider in the small body of literature on the topic.

Thoughts, feelings, and reactions about therapist absences. In the current study, the finding that therapists mainly felt happy to return to work did not concur with findings from previous research, which noted that therapists felt pressure to get therapy back on track again after the break (Bush, 1989). Participants in the current study were more seasoned than those in Bush (1989), however, so perhaps they felt more at ease with the absence than their less experienced counterparts. This explanation matches the earlier assertion that therapists are not trained in how to manage absences, but gain confidence with experience.

In clients, on the other hand, there were more varied reactions. In the current study, some appeared to be happier than usual in the first session back. It is curious whether this observed reaction was due to relief that they were able to return to therapy, or if they returned with an increased sense of self-efficacy after seeing they were able to survive the break and handle situations on their own using their newly-acquired skills. Other clients showed either no reaction or overt distress when reunited with the therapist. Literature suggests that this type of reaction can be expected and should not be feared by

the therapist. Instead, it can be used as a source of information for the therapist, and a chance to model a different response (Siebold, 1999; Stein et al., 1996).

Therapists' approach to return from absence. The approach therapists took to the first session back after their absence was a smaller focus of concern than the plans they made prior to the absence. Though participants in the current study, as is also suggested by the scant literature, worried less about the return than the initial leave, the first session after a therapist absence can be an important part of the therapy process (Bush, 1989).

The most prevalent finding here echoed that which has been found in the past, in that a main focus in the first session back is generally on catching up with the client or concentrating on how she/he experienced the absence (Barish, 1980; Bush, 1989; Lamb & Latona, 1989). Indeed, as Bush (1989) asserted, participants in this study did not attempt to prematurely push past discussion of the absence upon their return (i.e., they “caught up” after absence, shared some general details about absence), and perhaps as a result, they saw positive results in the cases discussed. This finding gives strength to the consideration of processing the absence with the client both before and after the break rather than shying away from such discussion due to guilt, insecurity, or any other therapist-generated reason. It appears that there can be a natural give-and-take in reunion sessions as well, as some participants opted to share some of their own absence details with their clients when they returned. Choosing to engage in this type of disclosure would again be subject to a therapist’s personal style and comfort, as well as the relationship with the individual client, but disclosing even a few details could be enough to bridge the first session back in a conversational, natural-feeling manner.

At some point in the first session back, some participants also chose to assess the plan of care and discuss the plan for therapy going forward. This approach seems to fit with the idea that it is important after a therapist-imposed absence to use a session to assess how the client did, bring him/her back to the present, and plan for the future. The first session back, according to this model, acts as a measuring stick, or a timeline, to get a sense of the client's progress thus far, and where she/her wants to go from there.

Not all participants in this study altered their approach to their first post-absence session. In fact, some participants reported not doing anything different in the reunion session than any of the sessions prior to the absence. It appears that within certain styles of therapy, or certain types of therapeutic relationships (i.e., strong/trusting/good relationship), the absence itself may not require much attention, and it can be beneficial to simply continue where the therapist and client left off. This seems to be the case less often, however, indicating that the default should be to process the absence with the client unless otherwise indicated.

Overall outcomes. After considering how therapists and clients think and feel about therapist absences and how therapists approach their own absences as a result of these perceptions, the remaining question is what impact these types of breaks in therapy have on the process as a whole. How are the therapist, client, and the therapy itself affected? What are the lasting effects of an absence on a therapist's future practice? What do therapists learn through absences?

First, although many therapists appear to have a great deal of fear and apprehension when considering taking extended leave, it appears that therapist absences are not all that harmful (Schafer, 2002; Siebold, 1999; Stein et al., 1996). To the contrary,

in the current study, the impact of the absences discussed by participants was overwhelmingly positive. Without exception, participants rated the overall impact of the specific absence as positive. Admittedly, this finding does not mean that none of the participants in the study have ever experienced a negative result of an absence. They could have all, through self-selection, discussed absences that were experienced more positively. Even so, this finding displays that absences may well prove beneficial for the therapy.

More specifically, participants noted both positive (i.e., participant felt refreshed, gained comfort for future absences, gained insight about the client and therapy, client gained/recognized own resilience, furthered the therapy relationship) and negative (i.e., increased workload/stress, client distress) impacts of the absence, with the former occurring more often than the latter. Although absences may involve challenges, therapists, particularly trainees and young professionals, should realize that what initially appears to be a bump in the road does not have to dictate the end result. Even if the client reacts in a way that causes the therapist to think her/his absence will be detrimental, how the therapist proceeds from that point could do more to determine the end result (Blanck & Blanck, 1974). Though participants in this study approached different types of absences in different ways, all cases reportedly benefitted by the absence, and most participants stated they would not change their approach. They were able to survive the absence discussed and then take information from it to better inform their planning for future absences.

Concluding Thoughts

Besides the impact absences have on therapists' individual cases, or even their practice as a whole, each absence a therapist experiences helps him/her to reflect on her/his views of therapist absences in general. Once therapists in this study were able to work through some anxieties about leaving their clients and consider their experiences retrospectively, they asserted that absences are not only necessary, but important for therapists to allow themselves to embrace and indulge. They still recognized that it is important for therapists to use due diligence to ensure a solid plan has been developed with their clients, but it appears that in doing so, therapists often find a more positive outcome than they expected. It seems that therapists may not give clients enough credit, and think that clients are more fragile than they truly are. Participants in the current study urged other clinicians to have more faith in their clients, and know that much of the time, they will be okay.

Limitations

Any study has room for improvement, and the current study is no exception. To begin, the original intention was to include only absences that lasted a minimum of two weeks, rather than one week. Due to significant difficulty finding participants, the criteria were relaxed. A two-week absence during therapy could have a very different feel and course than a break as short as a week, leaving a lot of room for variability and increasing the level of difficulty in finding trends across cases. Another limitation involves participant self-selection. As was previously discussed, every participant chose to discuss a case for which there was a positive outcome. Although the positive finding is meaningful, it also suggests that the study may have missed out on being able to examine

what causes absences to be harmful or to have negative consequences. Conclusions are able to be drawn about what can be helpful in the management of absences, but not regarding mistakes therapists should aim to avoid. Moreover, different outcomes may have been observed if the client population was limited to severe cases, such as those struggling with personality disorders. In addition, since therapists were the participants, the clients' actual experiences were left to their therapists' speculation. Finally, the participant pool consisted entirely of female therapists, most of whom identified as Caucasian/White. It is unclear how adding a male perspective or having more racial/ethnic diversity would have altered the results, though conducting further research on the topic with a more diverse participant pool may uncover cultural considerations that were not unearthed in the current study.

Implications

Training. Given the scant literature, as well as assertions made by participants in this study, training directly addressing therapist absences is practically nonexistent. Based on therapists' accounts, more focus is needed both formally in a classroom setting and through on-site supervision regarding the management of therapist absences.

The matter of formal classroom training is a fairly straightforward, though far from simple, solution. Managing therapist absences needs to be incorporated into the curricula. As it may take a long time for a topic that is rarely addressed to make a substantive appearance in the majority of textbooks, an initial step could be for those teaching counseling skills to devote attention to absences each semester. A natural inroad into such a discussion could be in the latter half of the semester as students are naturally starting to think about their own vacations. The reality of this topic becoming a core

component of training, though, is that substantially more attention will need to be paid to therapist absences before they find their way into the materials instructors use to teach. Some classes into which discussion of absences could be naturally inserted are introductory counseling skills, ethics, and practicum- and internship-accompanying classes.

The other area in which absences need to be broached with more purpose than currently reported is on-site supervision. Therapists consistently report gaining confidence through experience with absences, as well as more positive results for themselves and their clients. If supervisors broach the topic with supervisees before their first absence and address it in a way that conveys normalcy rather than shame or fear, they can help positively shape trainees' views going forward. Additionally, giving this subject more of a focus may also protect clients. A combination of classroom teaching and supervision may reduce the stigma many therapists have around abandoning their clients via an absence, and may help them understand how to properly work their absences into the therapy process. This could help their clients in the short-term, and could improve therapists' long-term self-care.

Practice. Beyond training, this topic has practical implications. Seasoned therapists regularly report longing for guidelines regarding how to approach their own absences. At the moment, after finding little in the extant literature, therapists often must improvise and develop their own approach to absences. Such an approach sets a low standard in the field, and may focus only on harm reduction. Clinical practice guidelines regarding therapist absences could provide therapists with help in their decision-making process, and shift the focus to beneficence rather than purely nonmaleficence. As new

research emerges, guidelines could be updated. At the moment, almost any informed guidelines would be an improvement, particularly for therapists with fewer resources available to them.

Using a combination of the extant literature and findings from the current study, some initial recommendations can be made. First, it is clear that absences should be addressed with the client with enough time to collaboratively create a plan. The therapist should have emergency contacts already available to give to the client upon discussion of the plan, though therapists need not rush to set up an appointment with a substitute therapist unless clinically-indicated (e.g., high-risk client). Therapists should also ensure that those at their clinics, particularly any staff who may interact with clients or provide coverage during leave, are updated before the absence regarding the plan. Therapists should not shy away from discussion of the absence, and should devote time to process it before and after with the client, as appropriate. When discussing the absence prior to its start, therapists should not address it as an impending abandonment that must merely be survived, but rather as an opportunity for growth and skill utilization. Assigning the client homework with the promise of debriefing following the absence can be a useful way to maintain client engagement. Finally, practicing clinicians should fight the urge to unduly limit their absences. Some concerns about clients during absences prove to be unfounded, and potential for burnout is high when therapist self-care is not adequately maintained. With a solid plan and acknowledgement that therapist and client are on the same page, both therapist and client distress can be reduced.

Research. This study also has a number of implications for research. The main takeaway is that much more empirical research is needed on therapist absences. With

such a small base of literature, it is not surprising that the topic is a ghost in training and practice.

The current study examined the different stages of absences, but only from the therapist's perspective. A logical next step would be to conduct a study of similar design from the client's perspective. Also, although it was not the intent from the outset, only successful cases were discussed by participants in this study. Examples of absences that were negative, or harmful, could provide useful information to compare to the successful cases, from both the therapist's and the client's point of view.

Different types of absences could also be investigated. This study did not discriminate based on the type of absence, but instead by the length of time. Distinct types of absences could be studied to examine factors unique to each (i.e., family leave, medical leave, vacation), such as the potentially different levels of, and considerations for, therapist self-disclosure. Studies could also be conducted focusing on therapists taking leave in different settings with different resources available (i.e., hospital, community clinic, private practice, university counseling center) or with different populations (i.e., inpatient versus outpatient, various diagnoses, non- or minimal-English speaking clients, low SES clients, clients of various cultural backgrounds). Finally, therapists in the current study reported a variety of theoretical orientations. Future studies could be conducted with a focus on the management of therapist absences by therapists within specific theoretical orientations. Such studies could produce recommendations for those looking to tailor their approach to absences to better fit their overall practice.

Conclusions

Therapist absences are unavoidable, yet may prove to be crucial events of the therapy process, even if they have been largely ignored in the literature. Without the proper attention paid to therapist absences in training, it is unsurprising that trainees and young professionals often express consternation when thinking about managing their own absences. Some therapists view taking time off in such a negative light that they attempt to limit their own absences as much as possible. This study suggests that resorting to such lengths is unnecessary, and results in a lost opportunity, as absences may actually further client growth and help the therapy. The hope is that this study not only adds to the scant literature and begins to fill in some gaping holes, but also that it sheds light on an unnecessarily taboo topic and nudges readers to think of their absences not as something harmful to be avoided, but as an essential part of therapy to be accepted and used beneficially, whenever possible, for both themselves and the therapy process.

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Appendix A: Demographic Form

Your Age: _____

Your Sex: _____

Your Race/Ethnicity: _____

Your Professional Licensure: _____

Your Professional Experience:

Number of years of practice post-licensure: _____

Approximate % of professional time devoted to psychotherapy practice: _____

In what types of settings have you seen clients? _____

Your theoretical orientation: _____

Average number of times per year that you are absent from your practice for at least 2 weeks: _____

Your Name: _____

Your Phone Number: _____

Your Email Address: _____

Convenient times you can be reached by phone during the next few weeks (please indicate if you plan to be away in the next few weeks):

Days/EveningsTime (please indicate time zone)

THE INFORMATION YOU PROVIDE HERE WILL BE SECURED BY THE
PRIMARY RESEARCHER AND WILL NOT BE RELEASED IN THE DATA SET.

ANY MANUSCRIPT ARISING FROM THIS STUDY WILL PRESENT SUCH DATA ONLY IN AGGREGATE FORM.

Form will be separated here

Please indicate the address to which the results may be sent in 12-18 months

Appendix B: Informed Consent Form

MARQUETTE UNIVERSITY
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS
Anticipated Therapist Absences
Graham Knowlton
Department of Counselor Education and Counseling Psychology

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

PURPOSE:

- The purpose of this research study is to investigate interruptions in the therapeutic process caused by anticipated therapist absences.
- You will be one of approximately 15 participants in this research study.

PROCEDURES:

- You will be sent the demographic form, informed consent form, and interview protocol to fill out and return to the PI
- Upon receipt of your completed consent and demographic forms, the PI will then contact you, schedule an interview time, and proceed with the interview
- Interviews will take place over the telephone, and will be audio-recorded to ensure accuracy
- The interview will address all three stages of therapist absences (before, during, and after)
- The interview will begin with some opening questions about your general thoughts regarding therapist absences. You will then be asked about a specific example of a time when you were absent during the therapy process. You will be asked specific follow-up questions detailing before, during, and after the absence in question, as well as your thoughts about the overall experience. Lastly, there will be a closing section, where you will be asked about some final thoughts regarding the subject matter, and questions related to the interview itself.
- Recordings will be transcribed and destroyed after completion of the study
- You will be assigned a code number, which will be used to identify your transcript
- Quotations will be used, but will never be attached to any names
- All identifying information will be removed from the transcripts
- You will be given the opportunity to review the manuscript prior to its publication to ensure that your confidentiality has been maintained

DURATION:

- Your participation will consist of completion of the demographic form, which will take about 5 minutes, and 1 audio-recorded telephone interview, which will last roughly 1 hour.

RISKS:

- During the course of the interview, you may encounter subject matter that is upsetting (e.g., when describing a negative experience related to your absence). If this issue arises, your interviewer is a doctoral student in Counseling Psychology, and has been trained to respond appropriately, including being able to refer you to the proper services if necessary
- Although your privacy is very important, if you talk about actual or suspected abuse, neglect, or exploitation of a child or elder, or if you talk about hurting yourself or others, the researcher or other study team member must and will report this to the Bureau of Milwaukee Child Welfare, the Wisconsin Department of Children and Families Services, or law enforcement agency.

BENEFITS:

- Benefits include processing through therapeutic situations, gaining clarity/understanding of your own thoughts surrounding therapist absences, and contributing to the body of research within the field.

CONFIDENTIALITY:

- Data collected in this study will be kept confidential
- Private identifiable data (PHI) should not be discussed or disclosed unless appropriate HIPAA authorizations have been obtained
- All your data will be assigned a code number rather than using your name or other information that could identify you as an individual.
- The key linking names to ID numbers will be stored in a password-protected folder on the PI's computer and will be kept separate from study data
- Audio recordings will also be stored in a password-protected folder on the PI's computer and will be kept separate from study data. Recordings will be destroyed after completion of the study.
- When the results of the study are published, you will not be identified by name.
- Direct quotes will be used in reports or publications, though, as stated, all identifying information will be removed, and you will have the opportunity to review the manuscript to ensure confidentiality.
- The data will be destroyed by shredding paper documents and deleting electronic files 3 years after the completion of the study.
- Data and/or findings from this study may be used for future training, education, or research purposes
- Your research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

VOLUNTARY NATURE OF PARTICIPATION:

- Participating in this study is completely voluntary, and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.
- If you choose to withdraw from the study, data from your interview will be destroyed.

- You may skip any questions you do not wish to answer.
- Your decision to participate or not will not impact your relationship with the investigators or Marquette University.

ALTERNATIVES TO PARTICIPATION:

- There are no known alternatives other than to not participate in this study.

CONTACT INFORMATION:

- If you have any questions about this research project, you can contact Graham Knowlton, M.S. (graham.knowlton@marquette.edu).
- If you have questions or concerns about your rights as a research participant, you can contact Marquette University's Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT, AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

Typed name of Participant:

Date:

Appendix C: Interview Protocol

Thank you very much for your participation in this study on therapist absences. We appreciate your willingness to give your time to help us examine this important topic. This interview will begin with some general questions about your approach and views toward your own and other therapists' absences. You will then be asked about a specific example of a time when you were absent during your practice of therapy. Finally, we will conclude with some closing questions.

As a reminder:

- The client who experienced your absence needs to be at least 18 years of age whom you saw as an outpatient in individual psychotherapy within the last two years
- At the time of the absence, you needed to have already seen the client for a minimum of 4 weeks, and a minimum of 4 sessions
- You need to have seen the client for at least 1 session after the absence
- The absence lasted 1-6 weeks, during which you missed at least 1 session with the client whom you are discussing that ordinarily would have been scheduled, and you knew about the absence at least 2 weeks in advance
- Additionally, you and your client did not set up appointments with a substitute therapist during the absence
- However, if something did happen during the absence that led the client to seek professional help, we also welcome your participation
- When you saw this client, at least 50% of your professional time must have been devoted to psychotherapy practice or activities related to the practice of psychotherapy
- If you have had more than 1 absence with your client, please select one absence that you'd like to talk about in depth

All information will be kept completely confidential by assigning each participant a code number and deleting any identifiers.

Opening Questions

1. When therapists are going to be absent during psychotherapy, they often experience a range of thoughts/emotions. What types of thoughts/emotions do you typically experience leading up to your absences?
2. How would you describe your general approach to your absences?
3. To what extent do you adjust this approach with different clients?
4. What, if any, training or supervision have you received regarding therapist absences?

Specific Example Questions

5. Now I would like you to talk about a time **with a specific client when you were absent during the therapy process.**

Before the Absence

- a. Please tell me a bit about this case (e.g., client demographics; focus, duration, frequency, setting of therapy; therapeutic relationship; reason for absence; at what point in the therapy the absence occurred and how far in advance you knew; was this your first absence with this client).
- b. Please describe your thoughts regarding taking this particular break or absence at this specific time.
- c. Please describe any discussions you had with the client prior to your absence, about your upcoming absence.
- d. Please describe any discussions you had with anyone else prior to your absence, about your upcoming absence related to this client.
- e. What was going on just before the absence (with you, the client, the therapy)?
- f. What was your plan with this client for the time you would be away, and what was your reasoning for this plan?
- g. What feelings/thoughts did you experience related to the absence as it approached?
- h. What was the client's reaction to the news/approach of your absence?
- i. Please describe your approach to the last session before your absence.

During the Absence

- j. Tell me about any significant events that occurred related to your work with this client during the time you were away.
- k. What, if any, feelings/thoughts did you experience regarding therapy with this client during your absence?

After the Absence

- l. Please describe your approach to the first session with this client after your absence.
- m. What, if any, reactions did you notice in the client upon your return?
- n. Please describe any discussions you had with the client about your absence, after returning from your absence.
- o. What effects did your absence seem to have (on you, the client, the relationship, the therapy process)?

Overall Experience

- p. Overall, would you say this absence had a positive/helpful or negative/harmful effect on the therapy with this client?
- q. What leads you to classify this absence as either positive/helpful or negative/harmful?
- r. Looking back, what, if anything, would you have done differently surrounding this absence?
- s. How did this experience affect your approach to your absences with other clients?
- t. Is there anything else about this experience that you'd like to share?

Closing Questions

6. After having discussed your experience, what final thoughts would you like to share with other clinicians regarding therapist absences?
7. Why did you choose to participate in this interview?
8. What was your experience of the interview?
9. Is there anyone else you would recommend to participate in this study?