Clinical Psychologists’ Experiences of Client Non-attendance in Health Service Practice: A Conflict of Responsibilities?

Thesis submitted in partial fulfilment for the degree of Doctorate in Clinical Psychology at the University of Leicester.

Alison Tweed
Department of Clinical Psychology

July 1998
Acknowledgements

I would like to thank the following people for their involvement in this study; to Denis Salter for his invaluable supervision and support; to Zazie Todd for her comments on the first draft of this paper and her facilitation of the qualitative research group. Also to my colleagues in the qualitative research group for their help. I would also like to thank the participants of the study for their time and reflections. Finally, to John, my family and my friends for making the whole process survivable.
ABSTRACT

Within psychotherapy process research, the effects of client non-attendance upon therapists has generally been neglected. The present study interviewed six qualified clinical psychologists concerning their experiences of client non-attendance in health service practice. Their accounts were analysed qualitatively using a grounded theory method. Based on the analysis, a core category was identified and termed Responsibility. This highlighted conflicting relationships between participants’ responsibilities in several areas. These included participants’ responsibilities to their employers, their clients and themselves. A process model pertaining to non-attendance was also developed. Client non-attendance was seen to produce a level of disruption, experienced by participants as an affective reaction. This reaction was often experienced in terms of negative affect. In response, re-organisational strategies were utilised to restore equilibrium. Reasons were suggested as to why negative affective reactions were often experienced. These included factors concerning therapeutic competency, but in a wider context also reflected upon the profession’s espousal of an ‘all-knowing’ expert identity. This was seen to be incongruent to the complexities of clinical practice. The role of the re-organisational strategies were discussed and included strategies as a means of repairing therapeutic alliance breaches and as defences against anxiety. Implications in terms of clinical psychology training and the profession are discussed. A critical reflection on the study is also presented.
CONTENTS

Page No.

List of pictures and figures v

List of appendices vi

Introduction 1
  Non-attendance: A topic in need of investigation 2
  Factors influencing termination of therapy 5
  The effects of termination on therapists 9
  Termination and clinical practice 11
  Preventing premature termination 12
  Summary 14
  Rationale for the study 15
  A statement of the aims of the study 18

Method 19
  An overview of qualitative research 19
  Good practice in qualitative research 22
  Grounded theory 24
  Interviewing as a research tool 32

  The present study - participants 34
  The researcher 34
  Research design 36
  Procedure 36
  Methods used to enhance research quality 43
Account of the Analysis

The core category: Responsibility

The process model

Main category – Being a clinical psychologist

Main category – Non-attendance

Main category – Experiencing disruption as affective reaction

Main category – Re-organisation to equilibrium

Main category - Learning

Discussion

Responsibility as the core category

The process model

Negative affective reactions to non-attendance

The role of the re-organisational strategies

Summary

Critical reflection on the study

Implications for clinical psychology

Implications for psychotherapy process research

Suggestions for further research

Conclusions

References

Appendices
<table>
<thead>
<tr>
<th>List of pictures and figures</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picture 1  An example of a discharge letter following client drop out</td>
<td>1</td>
</tr>
<tr>
<td>Figure 1  Example of post-interview note from researcher’s field diary</td>
<td>39</td>
</tr>
<tr>
<td>Figure 2  Example of a memo from researcher’s field diary</td>
<td>42</td>
</tr>
<tr>
<td>Figure 3  The core category and the process model</td>
<td>49</td>
</tr>
<tr>
<td>Figure 4  Being a clinical psychologist</td>
<td>55</td>
</tr>
<tr>
<td>Figure 5  Experiencing disruption as affective reaction</td>
<td>68</td>
</tr>
<tr>
<td>Figure 6  Re-organisation to equilibrium</td>
<td>77</td>
</tr>
<tr>
<td>Appendix</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Ethics Committee approval letter</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>Participants’ consent form</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>Participants’ information sheet</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>Example of open coding</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>Summary of initial research findings for participant validation</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>Interview transcripts – bound separately</td>
</tr>
</tbody>
</table>

Page No. 143
Dear Dr. White,

Re: Joan Brown DoB 01/01/50
200 Main Road, Leicester.

Further to my report of the 21st January 1998, I have seen Mrs. Brown on a further four occasions. However, in recent weeks, Mrs. Brown has cancelled her appointments and I have received a message that she no longer wishes to attend for sessions. I am therefore discharging Mrs. Brown back to your care.

As discussed in my formulation report, I felt that Mrs. Brown’s difficulties were functional in nature. She has relinquished certain responsibilities over the years and is reluctant to take them back as she believes that her depression will increase to an excessive level. Although some of our work explored these issues, Mrs. Brown remained ambivalent about seeking to change. Interestingly, in our final meeting, Mrs. Brown began to question and explore how her future might be different if she was no longer depressed. It is my hypothesis that Mrs. Brown found this too threatening to pursue further and responded by cancelling her appointments.

It is possible that Mrs. Brown was not fully prepared to undertake this kind of work and feared the concept of change too anxiety-provoking. However, Mrs. Brown described wanting to tackle her difficulties, so this does not preclude that in the future she will be more adequately prepared to try and address these issues. Mrs. Brown is aware that she will need psychological input in the future, she can discuss this with yourself.

Please contact me if there is anything further you wish to discuss.

Yours sincerely,

Alison Tweed
Clinical Psychologist in Training

"Mental Health Matters"

Chairman: Mr. R. W. Green BA. M.Ed. FRSA
Chief Executive: Mrs. B. H. Kennedy BA, MBA, N.HSM. Dip HSM. FRSA

Dr. White,
The Surgery
100 Main Road
Leicester

Leicestershire Mental Health Service
NHS Trust

Please ask for: Alison Tweed
Our ref: AT/1AG/
Your ref:

Mr. K. A. W. Green BA. M.Ed. FRSA
Mrs. B. H. Kennedy BA, MBA, N.HSM. Dip HSM. FRSA

IDENTIFYING MATERIAL HAS BEEN ALTERED

South Charnwood (Adult) Community Health Team
Corporate Offices, Bridge Park Road, Thurmaston, Leicester, LE4 8PQ

Picture 1: An example of a discharge letter following client drop out.

The Introduction section reviews the research literature surrounding and related to the phenomenon of non-attendance. A rationale for the present study is also presented alongside a statement of the study’s aims.
Non-attendance: A Topic in Need of Investigation

Non-attendance may be considered to be the failure of a client to attend for a scheduled appointment, which has not been cancelled by the client or therapist beforehand. Within British clinical psychology, failure of clients to attend for scheduled appointments without prior notice is a common problem. It has been difficult to acquire complete figures on the proportion of scheduled appointments that are not attended by clients. However, figures concerned with the numbers of clients who do not attend initial appointments suggest that this may lie anywhere between one-fifth and one-third of all clients referred (Gerhand & Blakey, 1994; Keen, Blakey & Peaker, 1996). Of a similar magnitude is the number of clients who discontinue therapy after one or two appointments. This has been suggested to be around twenty per cent (Trepka, 1986).

Hughes (1995) suggests that overall, around one-third of all clients drop out of therapy early. However, this is not a purely British phenomenon, or specific to clinical psychology. Garfield (1994) has quoted as high as a forty per cent premature termination rate in some United States surveys of clients referred to psychotherapists. Interestingly, Garfield also reports that if clients do not discontinue at the first or second interview, the median time the majority of clients stay in therapy is only between five and eight sessions. As can be seen, client non-attendance and drop out from therapy is an experience all therapists encounter in their working lives on a fairly regular basis (see Picture 1 as an example). However, it seems that there is a paucity of research investigating how non-attendance per se, affects therapists. Perhaps then, the time is right to open this area of investigation.

In looking at the published literature in related areas, the area of premature termination as a therapy event has received some attention. However, the majority of this research has attempted to define client variables that are predictive of premature termination (e.g. Bergin & Garfield, 1994), or have questioned clients after they have terminated therapy for their reasons for this (e.g. Hughes, 1995). Studies that have
investigated therapists' reactions to premature termination have done so in the form of detailed case studies (e.g. Strupp, Schacht, Henry & Binder, 1992; Davison, 1995). There are very few studies of therapists' reactions to premature termination that have attempted to widen the area away from the analysis of single cases. One exception to this is a study by Hill, Nutt-Williams, Heaton, Thompson & Rhodes (1996), where eight therapists were interviewed on their recall of impasses in psychotherapy.

Apart from the relative frequency of non-attendance in clinical practice, there are other reasons why client non-attendance is a topic in need of investigation. Within an ethnomethodological perspective, Garfinkel (1963) suggested an alternative procedure for the investigation of everyday social action. Up to the early 1960s, researchers had tended to investigate features of social action based upon the stable organisation of activities. Garfinkel suggested that by investigating disorganised interaction, this would illuminate how social structures are ordinarily and routinely maintained. Namely, this is to investigate social interactions when they do not go to plan, termed by Garfinkel as 'breaches'. In terms of the present study, the attendance of clients to pre-arranged appointments may be seen as a form of expected social interaction. Client non-attendance, therefore, may be seen as a breach of this interaction and investigation of this area may illuminate processes not normally accessible or obvious.

Within the psychotherapy process literature, some attempts have been made to investigate 'breaches' in the therapeutic alliance between therapist and client. Therapeutic alliance breaches have been described by researchers in different terms, including 'therapeutic alliance ruptures' (Safran, Crocker, McMain & Murray, 1990); 'therapeutic challenges' (Agnew, Harper, Shapiro & Barkham, 1994) and 'misunderstanding events' (Rhodes, Hill, Thompson & Elliott, 1994). Despite the differences in terminology, it is generally agreed that 'mis-alliances' occur on a fairly regular basis between therapists and clients. The therapist is able to resolve a proportion of these difficulties and therapy continues. However, this is not always the case and the client may terminate therapy prematurely. Clients' failure to attend a
scheduled appointment may therefore be indicative of a therapeutic alliance breach and may suggest that the client will not return to therapy.

The examination of therapeutic alliance breaches has only recently become an area of interest for psychotherapy process researchers. Up to that point, a large proportion of psychotherapy process research had been attempting to investigate two main areas. The first was to try and explicate the ‘active ingredients’ of therapy, the second was to try and assess the comparative efficacy of different types of psychotherapy. A frequently quoted testament to this research is ‘The Handbook of Psychotherapy and Behavior Change’ (Bergin & Garfield, 1994). Although a great deal was learnt about specific processes of therapy, it has been more difficult to find consistent answers to the two main questions. Indeed, in recent years, criticism has been aimed at the appropriateness of asking these particular questions (Butler & Strupp, 1986) and indeed, whether the methods used to try and answer them are adequate (Stiles, Shapiro & Elliott, 1986).

Prompted by the stagnation of psychotherapy process research in the late 1980s, and by empirical evidence suggesting that the quality of the therapeutic alliance is the best available predictor of therapy outcome (Safran, 1993), researchers shifted their emphasis to different factors in psychotherapy processes. The investigation of therapeutic alliance breaches enabled researchers to attempt to address several issues. These included a means of accessing possible mechanisms of change within therapy (Safran et al 1990; Agnew et al, 1994) and to increase understanding about how therapists repair breaches in the alliance (Rhodes et al, 1994). Although the investigation of therapeutic alliance breaches has been promoted as an area worthy of research (Safran et al, 1990), relatively few researchers have focused on this topic. Interestingly, of those researchers that have, several have employed qualitative methodologies (Agnew et al, 1994; Rennie, 1994; Rhodes et al, 1994; Hill et al, 1996).
Factors Influencing Termination of Therapy

Although the failure of clients to attend for scheduled appointments does not necessarily indicate that clients have terminated therapy, it is certain that in some instances this is indeed the case. Therefore, this section examines the various reasons why clients terminate prematurely from therapy. It has been suggested that there is a distinction to be made between clients who never attend for appointments, or attend only once, and those that drop out subsequently (Hughes, 1995). As the following section will demonstrate, some reasons discussed will be applicable to termination at initial appointments, whilst others may be applicable once therapy is underway. However, there is also crossover and interaction between the variables examined.

Dissatisfaction. This has been suggested to be a major cause of premature termination, most applicable in those instances where clients have attended for one session or more. Hughes (1995) in a small scale British study investigating clients’ reasons for terminating therapy, found that the majority of reasons given were associated with some form of dissatisfaction with the sessions. These included clients’ perceptions that therapy was not progressing, that therapy was not dealing with relevant difficulties and other factors pertaining to the skills and personality of the therapist. In a similar type of study, this time investigating psychologists’ and general practitioners’ views on the reasons for clients terminating prematurely, Gerhand & Blakey (1994) found that the most frequent response given concerned a perception that clients disliked treatment in some way. Further elaboration on this reason given by the psychologists in the study included clients not wanting to be seen by a clinical psychologist, clients’ dislike at disclosing embarrassing material and clients not accepting a psychological explanation of their problems.

Safran et al (1990) identified several therapeutic alliance rupture markers within sessions that may ultimately lead to clients terminating therapy prematurely. Included were clients’ overt and indirect expression of negative sentiments. This may reflect clients’ perception that the therapists did something that was incongruent to
what they wanted or needed (Rhodes et al, 1994). As Rhodes et al suggested in their study investigating resolved and unresolved misunderstanding events, a common negative sentiment expressed by clients was anger and frustration towards the therapist. However, these feelings are not always expressed in explicit terms and indeed, previous research has suggested that therapists are often unaware of these sentiments (Hill, Helms, Spiegel & Tichenor, 1988; Hill, Thompson & Corbett, 1992). If therapists are unaware of these feelings, or are unable to resolve them, premature termination may be a frequent outcome.

Perceived or actual mistakes on the part of the therapist may also be seen as a source of dissatisfaction for clients, leading to premature termination of therapy. Indeed in Hill et al's (1996) study investigating therapists' recall of impasses, therapist mistakes were perceived to be the most probable cause of the impasse event. The mistakes described included the therapist being unsupportive, not being directive enough, changing techniques too quickly and underestimating clients' pathology. Similarly, case studies of clients terminating prematurely have also been analysed in terms of errors therapists had made. For example, Davison (1995) examined several possible errors he may have made in the case of a client that terminated therapy after five sessions. Strupp, Schacht, Henry & Binder (1992) critically examined errors made by a therapist in their Vanderbilt II project in the premature termination of 'Jack M."

**Expectations.** Lack of mutuality between the expectations of therapy for clients and therapists has been suggested as another major reason for premature termination (Balfour, 1986; Garfield, 1994). Hughes (1995) has suggested that clients may be looking for a 'quick cure' for their difficulties, whilst therapists may have different conceptualisations of improvement and the time needed to achieve this. Hughes cites an interesting study by Kupst & Shulman (1979) in which the general public and mental health workers were asked whether they agreed with the following statement; 'If I saw a professional helper, I would expect it to take a long time before I solved my problems'. Only 17 per cent of the general population agreed with this, compared
to 96 per cent of mental health workers. This demonstrates that there may indeed be a lack of mutuality of expectations concerning the duration of therapeutic work.

Unrealistic expectations of clients compared to therapists were also the focus of a study by Tinsley, Bowman & Westcot Barich (1993). The authors questioned counselling psychologists on their perceptions of the occurrence of unrealistic expectations on behalf of their clients. The findings revealed that the sample perceived most of their clients to have unrealistically high or low expectations about therapy. Unrealistically low expectations were most frequently related to the personal contribution that clients would have to make to therapy, whilst unrealistically high expectations concerned the prowess of the therapist and the presence of a facilitative environment. The authors suggested that unrealistic client expectations could have several detrimental effects within therapy including, a decrease in clients’ motivation and reduction in the therapists’ influence. Ultimately, premature termination may be the result.

Demographic Factors. There have been a variety of studies attempting to predict those clients that are likely to terminate therapy prematurely based on the analysis of demographic factors (Bergin & Garfield, 1994). In a review of this research, Garfield (1994) examined evidence from several studies investigating the relationship between demographic factors and clients who terminate early. The author found no clear relationship between clients’ length of stay in therapy and variables such as age, gender, ethnicity or psychiatric diagnosis. The only demographic variables that were related to premature termination were clients’ socio-economic status (SES) and education level. However, as may be expected, these two variables are highly correlated. In a British study, Trepka (1986) also found an influence between socio-economic status and premature termination, with lower SES a predictor of increased rates of termination. It is not clear how lower socio-economic status increases rates of premature termination, although it may be related to difficulties in identifying with (mostly) middle class therapists, greater practical difficulties in attending and cultural expectations concerning help-seeking behaviour.
As already mentioned, practical factors may influence clients' attendance rates. These include factors such as transport difficulties, finding babysitters and taking time off work. For example, Garfield (1963) found that half of his sample of clients who terminated therapy early gave practical reasons for this, including childcare problems and arranging time from employment.

Waiting Lists. In a recent survey examining waiting lists of clinical psychology departments in the United Kingdom, the British Psychological Society (1993) found that over 73 per cent of responding clinical psychology departments had waiting lists. Over 44 per cent of prospective clients waiting on these lists waited over six months to be seen, and 15 per cent waited over a year. It is not known whether the time clients have to wait to be seen influences initial attendance rates and subsequent premature termination, although intuitively it seems as if there will be a relationship. An example from a recent study may support this idea. Stevenson, Hill, Hill, MacLeod and Bridgstock (1997) described a waiting list initiative whereby extra psychologist time was made available to assess clients waiting for up to 71 weeks to be seen for initial appointments. The authors found that almost 37 per cent of clients did not respond to an opt-in letter or did not attend for their initial appointment. There are several reasons why clients were not seen, although time spent on waiting lists may well be a factor.

It is certainly plausible that another relevant factor in whether clients attend initially or terminate therapy early is clients’ perceived improvement in their difficulties. In Gerhand & Blakey’s (1994) study, psychologists and general practitioners cited sufficient improvement in condition as a possible reason for clients’ early discontinuation of therapy. Clients may therefore attempt to receive help from other sources if therapist involvement is not readily available. As one of Hughes’ (1995) sample of early discontinuers stated, ‘it would be a lot better if there were a therapist on hand when you need one ... a mobile psychologist’.
Conflicts Over Dependency. In terms of the developing therapeutic relationship, a factor why clients may terminate prematurely is their fear of becoming dependent on the therapist. Early termination is therefore construed as the client maintaining a sense of control. Van Denburg & Van Denburg (1992) examined a case study of premature termination in light of three psychoanalytic perspectives. Commonalties between the theories revealed a central issue of the clients’ conflicts over dependency. The client emotionally distanced himself within therapy and in the end, asserted his self-sufficiency and separated from the therapist. Conflicts over dependency may be a useful way to conceptualise some termination events. This seems to reflect Safran’s (1993) view on the importance of therapeutic alliance breaches. ‘They are paradigmatic of a fundamental dilemma of human existence, i.e. the need to reconcile our innate desire for interpersonal relatedness and the reality of our separateness’ (p. 12).

From the previous discussion, it seems that there are a variety of reasons why clients terminate therapy early. These reasons may change depending upon whether clients have never seen therapists and do not attend for initial appointments, to whether clients terminate after one or two sessions, or further into therapy. However, premature termination can have an impact on therapists, as the following section will discuss.

The Effects of Termination on Therapists

As discussed in the previous section, clients may terminate therapy early for many reasons, although there is no doubt that on many occasions, clients feel negatively towards their therapists and are dissatisfied with the help they were receiving. However, therapists may also be affected negatively by premature termination. As Van Denburg & Van Denburg (1992) state ‘premature terminations are often not easy to swallow’ (p.189).
As already mentioned, Hill et al (1996) conducted a study investigating therapists’ retrospective recall of impasses in psychotherapy. Impasses were defined as stalemates in therapy, whereby progress was no longer possible and termination occurred. The authors found that after the impasse event, therapists reported several negative reactions including, frustration, anger, disappointment and feeling hurt by their clients’ actions. Some therapists also reported feeling confused or anxious about the impasse and several reported questioning their self-efficacy. Although the authors did not formally investigate the effects of these reactions in the longer term, they did report that the impasse event left lingering emotions for the therapists. These included feelings such as continuing self-doubt, rumination and worry. These feelings were reported to continue for months after clients had terminated therapy.

Even if termination of therapy is an expected event, therapists may still experience negative reactions. In a study investigating termination anxiety as it affects therapists, Martin & Schurtman (1985) found that therapists often felt uneasy about the ending of therapy and experienced a variety of affective reactions. They reported that therapists experienced feelings of loss, especially if they had unresolved issues of separation in their own histories. Feelings of guilt and sadness may also be experienced, often depending upon how the clients themselves are reacting to the ending of the therapeutic relationship. The authors reported that the general feelings of anxiety therapists experience in response to the impending cessation of therapy were based upon therapists’ transference and countertransference\(^1\) reactions over termination.

\(^1\)The concepts of transference and countertransference were initially derived within Freudian psychodynamic theory (D.L. Smith, 1990). Definitions of transference and countertransference are varied, but for the scope of this review, general definitions are provided. Transference may therefore be described as clients’ unconscious treatment of their therapists as surrogate figures from previous significant relationships, aspects of which are enacted within the therapeutic setting (D.L. Smith, 1990). A related phenomenon to transference, countertransference has been described as some of the thoughts, feelings and behaviours that therapists experience in relation to clients (Watkins, 1985). Countertransference can therefore be seen as a disruption of the analytic attitude of neutrality (D.L. Smith, 1990).
Similar negative reactions experienced by therapists in relation to termination have been reported in other studies. For example, Fair & Bressler (1992) reported that therapists experienced feelings of anxiety, guilt, anger and relief even in cases where they had initiated the termination process. Therapists in a study by Boyer & Hoffman (1993) also reported feelings of anxiety and depression in relation to termination. The intensity of these feelings was related to therapists’ own loss history and their perception of how the client would be affected by the termination of therapy.

As can be seen from this discussion, therapists can experience a variety of negative feelings in relation to the termination of therapy, even if termination is an expected event. Issues of transference and countertransference seem to influence the type and intensity of these feelings. As can be seen from the Hill et al (1996) study, the feelings therapists experience after a unilateral (the client’s) decision to terminate therapy can linger for a long period after the event. As will be discussed in the next section, how therapists react and cope with feelings associated with termination can have implications for their clinical practice.

**Termination and Clinical Practice**

As both Martin & Schurtman (1985) and Boyer & Hoffman (1993) suggested, therapists’ own histories of loss and separation can influence how they react to the impending termination of therapy. In terms of clinical practice, this may mean that the therapists do not adequately deal with the issues arising from the prospect of therapy ending. In Martin & Schurtman’s (1985) study, they suggested that therapists dealt with their own termination anxiety by engaging in certain defence manoeuvres, which were generally considered to be detrimental to the successful ending of therapy. The authors suggested that due to the significant contribution of therapists’ transference and countertransference reactions over termination, therapists need to learn as much as possible about themselves. Supervision and support from colleagues may be means of achieving a greater level of self-understanding.
Detrimental countertransference has also been discussed by Watkins (1985). He suggests that there are several different methods by which therapists can gain awareness and deal with these issues. These include self-analysis, personal counselling, supervision and referral. It was suggested that these methods be used preventatively, rather than remedially.

In terms of premature termination as opposed to expected termination, it seems that the above suggestions are equally, if not more applicable. This is in light of Hill et al.’s (1996) study that reported that most therapists believed their own personal issues were implicated in impasses that ultimately led to premature termination. In terms of positive responses to premature termination, several methods have been suggested for therapists to employ. These include contacting clients by telephone after non-attendance as a means of exploring difficult issues (Gilbert, 1992) and actively encouraging clients to return to sessions to enable the therapist to understand clients’ views (Ward, 1984).

As can be seen, termination, premature or expected, can prove to be a difficult period for clients and therapists alike. However, by therapists being aware of their own contribution to the therapeutic relationship through supervisory processes, they can gain awareness of how personal factors can influence therapy. This may enable therapists to work through impasses in therapy more effectively and reduce rates of premature termination. The next section discusses this in greater detail.

**Preventing Premature Termination**

From the literature investigating therapeutic alliance breaches, several recommendations have been made by the authors concerning how therapists may prevent an alliance rupture developing into an impasse, of which the clients’ termination of therapy is the inevitable result. Although a breach in the therapeutic
alliance can pose a serious barrier to continuing progress, it can also provide the therapist with indispensable information (Safran, 1993) and can lead to growth if resolved (Rhodes et al, 1994). As an initial recommendation, Hill et al (1996) suggested that therapists be trained to become aware of the variables associated with impasse events. Frequently checking clients’ satisfaction with the therapy may be a means by which impasses can be detected in their early stages and worked through so that premature termination is less likely to occur. Again, supervisory processes were seen as very important in helping therapists when sessions became difficult.

Safran et al (1990) also suggested that therapists be aware of markers in therapy that signal therapeutic alliance rupture. The authors suggested several means by which therapists could deal with these markers. These included attending to alliance ruptures, being aware of one’s own feelings and how these may influence the therapeutic alliance and accepting responsibility for one’s part in the process. Empathising with the clients’ experience and maintaining the stance of the participant/observer were also suggested. This would prevent the therapist becoming engaged in cyclical maladaptive patterns with the client, which may end in the client disengaging from therapy. Although therapeutic alliance ruptures were often difficult and threatening to address, the authors stressed the importance of focusing on the rupture as a means of resolving difficulties in the alliance.

Most usually, the recommendations made concerning how therapists may prevent premature termination have concentrated upon supervisory processes, both in terms of self-supervision and supervision from others. Self-supervision, or internal supervision (Casement, 1990) in particular is becoming an increasingly popular concept for the development of clinical skills and therapists’ professional growth. Donnelly & Glaser (1992) have suggested that internal supervision as a supervisory strategy is both economical and productive, with a better quality of service the expected outcome.
Casement (1993) has suggested that the functions of internal supervision evolve from the therapists' experience of their own therapy, from formal supervision and gaining clinical experience. Internal supervision involves the establishment of a 'mental island' by which therapists can reflect upon and observe sessions while in progress. In terms of identifying possible breaches in the therapeutic alliance, the internal supervisor can become aware of markers during the session and the therapist can attempt to deal with them as they arise. Therapists' personal issues may also be noticed during sessions and therapists can become aware of their possible influence.

Summary

As can be seen from the previous discussion, client non-attendance occurs on a regular basis. However, there is a paucity of research investigating how therapists react to this event. Non-attendance may be construed as a breach in a scheduled interaction and how therapists react to this may illuminate processes not normally accessible when the interaction runs smoothly. Clients' failure to attend may also indicate that clients have terminated therapy prematurely. The reasons for this are manifold, but include factors that have not been adequately identified or addressed by therapists within sessions. Whether therapists are able to work through these issues may be dependent upon their own personal factors impinging upon the therapeutic relationship. However, there are methods suggested in the literature by which therapists can attempt to reduce the incidence of non-attendance and premature termination.
Rationale for the Study

From the literature, client non-attendance is seen to be a common phenomenon in clinical practice. Equally, practising therapists will also during their careers, experience clients terminating prematurely from therapy once it is underway. However, there seems to be a general lack of research investigating how these events influence therapists themselves. Those few researchers that have investigated this area have tended to report that termination and premature termination in particular, can have a negative impact on therapists. In terms of the present study, the researcher was interested in practising clinical psychologists’ experience of non-attendance. How do clinical psychologists’ react to non-attendance and what do they do after the event?

The researcher chose to investigate the event of non-attendance because of its ambiguity of meaning for therapists. That is, the non-attendance event could have occurred for several reasons. For example, if a client has never attended for an appointment, their non-attendance may mean that they do not wish to attend. Similarly, if a client fails to attend for a scheduled appointment during therapy, this may suggest that the client has terminated prematurely, or has perhaps simply forgotten the time of their appointment. Equally, non-attendance may reflect an error on the part of the therapist, administrative or otherwise. Non-attendance became the focus of the study as, for the therapist it is an unscheduled, noticeable event that occurs on a fairly frequent basis and is easily accessible for therapists to recall.

Non-attendance may also seen as an important event in terms of being a clinician working within the National Health Service (NHS). Within the NHS, non-attendance may be seen by the organisation as leading to a waste of professionals’ time, producing extra administration tasks and exacerbating waiting lists (Keen, Blakey & Peaker, 1996). Therefore it was of interest to the researcher to investigate how procedures within departments were mobilised as a response to non-attendance.
Another area of interest for the researcher was based upon research suggesting that therapists' personal histories can influence the therapeutic alliance and possibly be implicated in therapeutic alliance breaches (e.g. Martin & Schurtman, 1985; Hill et al, 1996). Supervisory processes have been suggested as methods by which these issues can be identified and addressed. Processes such as internal supervision (Casement, 1990) may be a means by which therapists can self-monitor, and become aware of factors that may have a detrimental effect on the therapeutic alliance as they arise in therapy. This may be especially relevant for clinical psychologists within the NHS as calls have been made to promote reflexivity within the profession (Meikle, 1997). Therefore, the study aimed to investigate how clinical psychologists self-supervise after client non-attendance, and whether they sought other means of supervision to gain further understanding of their own processes.

It was felt that a qualitative methodology would be the most appropriate as a means of investigating this area. There are several reasons why this is the case. The first involves the lack of research conducted in the area of interest. As Turpin, Barley, Beail, Scaife, Slade, Smith and Walsh (1997) suggest, qualitative methods are ‘particularly advantageous when studying psychological phenomena not previously extensively researched’ (p.4). Similarly, Henwood & Pidgeon (1995) point out that qualitative methodologies may successfully be employed where theories about phenomena are non-existent or outdated.

Secondly, a qualitative approach can more effectively access the meaning of experiences through the eyes of particular participants than a quantitative approach (Henwood, 1996). A qualitative approach may also be seen as attempting to capture representations of meaning concerning a phenomenon and to explore and elaborate upon its significance (Parker, 1994). These ideas are applicable to the researcher's interest in learning about the phenomenon from clinical psychologists' own perspectives.
A grounded theory methodology in particular was chosen to analyse clinical psychologists' accounts for the following reasons. Firstly, the grounded theory approach places importance upon the generation of theory, grounded in an iterative process involving the continual sampling and analysis of qualitative data (Pidgeon, 1996). This enables the researcher to make conceptual sense of large amounts of data and provides rigorous procedures for researchers to develop ideas and build theory (Charmaz, 1995).

Building theory was seen to be an important aspect of the research process because, as the literature review revealed, there were no existing theories pertaining to the phenomenon of client non-attendance. As Henwood & Pidgeon (1992) note, theory generation is needed where existing theory is incomplete, inappropriate or entirely absent. Generating a new theory may also represent the most systematic means of synthesising and integrating knowledge pertaining to a phenomenon (Strauss & Corbin, 1990). It may also be a means by which abstract notions and knowledge can be generalised to different domains and settings. That is, a generated theory can be utilised as a means of considering hypothetical situations and possibilities (Peräkylä, 1997).

Secondly, a commonly used form of grounded theory has been carefully manualised and described by Strauss & Corbin (1990). This publication is easily accessible and can provide a good basis for learning how to practically apply the techniques of the method. In particular, the methods assist in structuring and organising data gathering and analysis and provide a rigorous and well-described means to maximise research findings in this under-researched area.

In terms of using grounded theory within the discipline of psychology, several authors have described grounded theory as a useful means of investigating psychological phenomena (Rennie, Phillips & Quartaro, 1988; Henwood & Pidgeon, 1995). In particular, Rennie et al (1988) and McLeod (1996) have suggested that grounded theory can be successfully applied to psychotherapy process research. In
the literature, psychotherapy process researchers using qualitative methodologies have often used grounded theory as the main method of analysis (e.g. Frontman & Kunkel, 1994; Rennie, 1994; Watson & Rennie, 1994). It has therefore been helpful to directly compare other researchers’ use of grounded theory in investigating psychotherapy process issues.

A Statement of the Aims of the Study

The present study aims to achieve the following:

- To investigate how clinical psychologists react to client non-attendance and the action taken after the event
- To investigate how departmental procedures are utilised as a response to client non-attendance
- To investigate how clinical psychologists self-supervise after client non-attendance and to ascertain whether other forms of supervision are sought.

It was felt that a qualitative methodology would be able to investigate these issues, based upon the perspectives of clinical psychologists themselves. In particular, a grounded theory approach would be utilised to achieve this.
METHOD

As outlined in the Introduction section, it was felt that the most appropriate form of enquiry for the present study was to use the qualitative method of grounded theory. The following section therefore provides an overview of the qualitative research paradigm and grounded theory as a particular form of qualitative inquiry. This includes a review of grounded theory's development, structure and use by researchers within the discipline of psychology. Also, literature concerning interviewing as a research tool is presented. The final part of the method section outlines the details and procedure of the present study.

An Overview of Qualitative Research

What is qualitative research? Qualitative research has been described as a field of inquiry in its own right that crosses disciplines, fields and subject matter (Denzin & Lincoln, 1994). The scope of the qualitative research paradigm covers numerous different approaches and methodologies. Definitions of the qualitative research paradigm are varied, but usually rest on a specific set of features. Such features include research that is generally undertaken in a naturalistic setting, as opposed to a laboratory or controlled setting (Guba, 1981). Here, the researcher is central to the sense that is made of the issue or problem under investigation (Parker, 1994). Data gathered tends to be non-numeric and may include interview scripts, written texts and visual material. This enables the researcher to be freed to explore multiple interpretations and meanings of the information (Henwood & Pidgeon, 1995). Grounded, emergent theory is preferred to *a priori* theory (Guba, 1981), with the emphasis on the development of concepts from the data (Henwood and Pidgeon, 1992).

History. During the 1950s and 60s the positivist conception of science was the dominant paradigm within psychology (Parker, 1994). Researchers primarily
attempted to discover laws governing relationships between ‘cause’ and ‘effect’. Most usually, investigations were carried out in laboratory settings, with the emphasis on the quantification of data to enable statistical analyses of the relationships between variables in order to test \textit{a priori} hypotheses. This model of scientific practice, which combines an empirical approach with the collection and statistical analysis of numerical data is known as the ‘quantitative paradigm’ (Henwood & Nicolson, 1995). 

However, during the late 1960s and early 1970s, some researchers within the social sciences were beginning to question the quantitative paradigm as the \textit{sine qua non} of scientific method.

Questioning of the quantitative method within psychology did not start to be voiced until the 1970s, but was influenced by developing ideas within sociology, anthropology and feminist research. Qualitative researchers in these areas had by this time a full complement of paradigms, methods and diverse ways of collecting and analysing research material (Denzin & Lincoln, 1994). Within psychology, it was becoming apparent to some researchers that the quantitative research paradigm had fundamental methodological problems (e.g. Gergen, 1978a; Harré & Secord, 1972; Tajfel, 1972). Most notably within the quantitative paradigm there was a general absence of the roles of language and meaning within the research setting (Parker, 1994). These were usually believed to be confounding effects which needed to be experimentally controlled.

\textit{Quality or Quantity?} Most usually, qualitative and quantitative approaches to research have been presented in opposition. This demarcation does little to encourage movement or interaction between the two, or promote continued understanding of various phenomena (Pope & Mays, 1995). However, Latour (1987) has suggested that both qualitative and quantitative research procedures aim to achieve similar outcomes, that is to derive coherent and combinable inscriptions in science.

Bryman (1988) presented a simplified version of the quality-quantity argument, in which two main strands of debate were identified: The first is described as the
'technical' version. Here, the choice of whether to utilise qualitative or quantitative methods is dependent upon pragmatic and methodological considerations involving 'their suitability in answering particular research questions' (Bryman, 1988; pp.108-109). Qualitative research may be described as the voice by which the sense of the phenomena can be carried, while quantitative research may be able to circumscribe the scope and extent of the topic (Parker, 1994).

The second strand of the quality-quantity debate has been described as the 'epistemological' version (Bryman, 1988). According to this version, the gathering, analysis and interpretation of data are carried out within a broader understanding of the nature and practice of science. This version more clearly separates the qualitative and quantitative approaches into two seemingly mutually exclusive, paradigmatic positions. The qualitative paradigm as naturalistic, contextual, interpretative and constructionist; the quantitative paradigm as experimental, hypothetico-deductive, positivist and realist (Henwood, 1996).

However, it is incorrect to assume that both the qualitative and quantitative paradigms are unitary concepts within themselves. Denzin & Lincoln (1994) have described several paradigmatic views within the qualitative and quantitative 'camps'. These views have their own stances on conducting research and the nature of inquiry. Denzin & Lincoln have listed several of these differences, including general ontological, epistemological and methodological issues and also more practical issues such as training, ethical stance and quality criteria (pp. 108-116).

Despite the distinctions between the qualitative and quantitative paradigms and the ensuing debate between them, this does not mean that they are in practice, mutually exclusive, or that either paradigm is necessarily 'better' than the other. Woolgar (1996) suggested that traditional scientific practice, which generally espouses the quantitative paradigm, is in fact, less objective and is more creative and contingent than the idealised version of itself. Equally, proponents of the qualitative paradigm need to be aware of the dangers of believing that qualitative methods are a more
reliable means of unearthing ‘the facts’ than quantitative methods. As Kvale (1986) states, the opposition of qualitative versus quantitative paradigms is a ‘pseudo issue’; both have their place.

In view of this, researchers have often argued for a mixture of qualitative and quantitative approaches (e.g. Silverman, 1993; Pope & Mays, 1995; Todd, 1998). Silverman (1984) for example, utilised both qualitative and quantitative methods in his study of oncology clinics in the NHS and private practice. Silverman (1993) argues that the use of numbers and counting in qualitative research can provide the reader with a quick sense of the data, which acts as a useful adjunct to the main qualitative analysis. Even feminist researchers who may be seen to be one of the first and strongest proponents of the qualitative paradigm have not ruled out the use of quantitative techniques. Griffin (1995) stated that ‘I am not suggesting that quantitative methods can never make any contribution to critical feminist social psychology’ (p. 120).

Good Practice in Qualitative Research

Although good practice in qualitative research is the aim that researchers within psychology would want to achieve, there are relatively few published coherent accounts of the methods by which this aim can be reached. In the last few years however, there have been moves to rectify this gap. Henwood & Pidgeon (1992) and Stiles (1993) have written two frequently cited articles, which have both detailed practical means to promote high quality research. Several of their ideas overlap and are presented as an amalgamation of the two articles.

Engagement with the material. Immersion in the research material may be seen as a means by which the qualitative research process is facilitated (Stiles, 1993). This includes an intimate familiarity with collected texts and more close involvement with research participants. Although it has been suggested that the developed theories
from the research should be easily recognisable to participants, Henwood & Pidgeon
(1992) have suggested that the researcher needs to be aware of the limitations of taking participants' accounts wholly at face value. As a means to overcome this, participants may be more closely involved in the analysis and interpretation process of the research, and the researcher may seek participants' feedback on research findings. Feminist researchers for example, espouse this commitment to reciprocity as a means to empower their participants (Burman, 1994). Again, the researcher needs to be aware of the power relationships that exist between participant and researcher and the effect this may have on the negotiation process (Henwood & Pidgeon, 1992).

The grounding of interpretations. A basic requirement of good qualitative research is that interpretation and theory derived from the research process should fit the data well (Henwood & Pidgeon, 1992). Glaser & Strauss (1967) argued for this view in their work, 'The Discovery of Grounded Theory', and there have been methods described as means of maintaining this standard (e.g. Strauss & Corbin, 1990). Stiles (1993) has suggested that readers external to the research project are consulted on the level of 'fit' between the data and theory. Again, participant's responses to preliminary interpretations may also be a means by which ideas can be grounded in participants' reality, although the provisos outlined above are relevant here also.

The development of rich and complex theory. Henwood & Pidgeon (1992) describe good theory as being rich and complex, which is integrated at diverse levels of generality. Cycling between the raw material, emergent concepts and categories and developing theory aids this creative process (Tindall, 1994). Reason & Rowan (1981) suggest the validity of the research 'is much enhanced by systematic use of feedback loops and going around the research cycle several times'. Elaborating developing theories may also be achieved by the use of 'negative case analysis' (Henwood & Pidgeon, 1992). Here, cases, which do not fit the emerging conceptual system, are explored as a means of widening and modifying the theories being developed by the researcher.
Reflexivity. In contrast to the quantitative research paradigm in psychology, the qualitative research paradigm acknowledges the ways in which the researcher and researched are interdependent in the research process (Henwood & Pidgeon, 1992). In terms of promoting high quality standards in qualitative research, disclosure by the researcher of his or her expectations for the study, preconceptions and theoretical orientation are recommended (Stiles, 1993). This enables the reader to gauge the stance and assumptions the researcher may hold. Similarly, as part of the investigation’s context, the researcher’s internal processes as the research progresses are also important. For example, Grafanaki (1996) and Mauthner & Doucet (1997) have written personal accounts of how the research process affected them as researchers. The use of a ‘reflexive diary’ has been suggested as a method to keep account of these changes and reflections (Lincoln & Guba, 1985).

Grounded Theory

A specific qualitative method widely used in the human sciences is Grounded Theory. This was developed and described in 1967 by two sociologists, Barney Glaser and Anselm Strauss in their book ‘The Discovery of Grounded Theory’ (Glaser & Strauss, 1967). The term ‘grounded theory’ was chosen to express the idea of theory about a phenomenon that is grounded in an iterative process involving the continual sampling and systematic analysis of qualitative data (Strauss & Corbin, 1990; Pidgeon, 1996). The qualitative data may include documentary evidence, fieldwork observations or interview transcripts of participant’s accounts; indeed any form of unstructured material (Henwood & Pidgeon, 1995). The term grounded theory is also used to describe a method for developing theory that is grounded in data and there are several publications describing the methodological process in detail (e.g. Strauss & Corbin, 1990; Charmaz, 1995).
**History.** During the 1960s when Glaser and Strauss were developing the grounded theory approach, sociological practice was becoming exclusively reliant on quantitative methods, for example large scale survey research (Pidgeon, 1996). Proponents of quantification were relegating qualitative research to a preliminary method to refine quantitative instruments as they further sought to reduce human experience to quantifiable variables (Charmaz, 1995). Sociological researchers at this time were preoccupied with the quantitative testing of propositions derived from a few ‘grand’ theories (Strauss & Corbin, 1994). Glaser and Strauss (1967) argued this led to impoverished theory which did not ‘fit’ with the real world. They therefore aimed to contribute toward ‘closing the embarrassing gap between theory and empirical research’ (p. vii).

By their development of grounded theory as a stance regarding the conduct of qualitative research and as a method, Glaser & Strauss (1967) challenged several concepts of the dominant (quantitative) research paradigm. They challenged the prevailing view of qualitative research as only a precursor to large quantitative projects and claimed the legitimacy of qualitative research in its own right. Their method challenged the belief that qualitative research was unsystematic and that theory could be generated and developed through interplay with non-quantitative data. Grounded theory’s purpose to generate and develop theory also challenged the notion that qualitative research could only produce descriptive case studies (Strauss & Corbin, 1994; Charmaz, 1995).

Glaser & Strauss also intended for grounded theory to cut across scientific disciplines and to be used to investigate a variety of phenomena (Strauss & Corbin, 1990). In psychology for example, researchers have argued that grounded theory is a useful approach for investigating psychological phenomena (e.g. Charmaz, 1995; Henwood & Pidgeon, 1992). Rennie, Phillips & Quartaro (1988) propose that grounded theory methods can help resolve the growing discontent with quantitative methods in psychology by offering a systematic approach for discovering significant aspects of human experience that as yet remain inaccessible to traditional methods of inquiry.
Grounded theory methods can also enable psychologists to study the development and change of individual and interpersonal processes (Rennie et al, 1988).

**Characteristics of Grounded Theory.** A major difference between grounded theory and other qualitative approaches has been argued as grounded theory's emphasis on theory development (Strauss & Corbin, 1994). The systematic methods of the grounded theory approach may also enhance the development of conceptually dense theory with considerable meaningful variation. A major contribution of the grounded theory approach has been the development of rigorous procedure and the undermining of the view of qualitative research as only intuitive and impressionistic. Charmaz (1995; p. 28) has identified several other distinguishing characteristics of grounded theory methods, based on her study of the literature and her own research. These include:

1) simultaneous involvement in data collection and analysis phases of research;
2) move away from the use of *a priori* hypotheses to the creation of analytic codes and categories developed from the data;
3) the development of theories to explain behaviour and processes;
4) detailed memo-making as an intermediate step between coding data and writing-up;
5) theoretical sampling, to refine categories, discover variation between them and to define their parameters and;
6) delay of the literature review.

**Grounded Theory of High Quality.** Three concepts are discussed that are held to be important factors in producing grounded theory of high quality. The first concept may be considered as a pre-requisite to many varieties of qualitative research, whilst the other two concepts may be thought as defining characteristics of the grounded theory method.

1) Theoretical Sensitivity. Theoretical sensitivity may be described as the personal ability of the researcher to recognise what is important in the data and to give it
meaning. It helps to develop theory that is faithful to the reality of the phenomenon under study (Glaser, 1978). Strauss & Corbin (1990) describe a researcher’s theoretical sensitivity as developed from four main sources. The first source is the literature. This includes various publications concerning the area of interest and has the effect of ‘sensitising’ the researcher to the phenomenon under study. The second source is professional experience. Here, the researcher may gain an understanding and knowledge of the workings of the field in which they wish to investigate. A third source has been described as the researcher’s personal experience. Finally, theoretical sensitivity may also be acquired throughout the research process as the researcher interacts with their data (pp. 41-47).

2) Constant Comparative Method. This is described as ‘a central feature’ of the analytic approach to conceptual and theoretical development (Strauss & Corbin, 1994). The principal analytic task is one of continually sifting and comparing elements throughout the research project. By using this method, the researcher becomes sensitised to similarities and differences within the data, as its complexity is explored (Pidgeon, 1996). The constant comparative method is therefore able to start ‘to generate theoretical properties of the data’ (Glaser & Strauss, 1967).

3) Theoretical Sampling. Theoretical sampling occurs as the analysis proceeds and helps the researcher fill out categories, to discover variation within them and to define gaps between them (Charmaz, 1995). It involves the active sampling of new cases with the goal of the elaboration of a conceptually rich, dense and contextually grounded account (Pidgeon, 1996). Sampling is conducted on the basis of concepts that are deemed theoretically relevant to the developing theory and the concentration is on development, density and saturation of categories (Strauss & Corbin, 1990). Charmaz (1995) has suggested that theoretical sampling is conducted later in the research to prevent premature closure to parts of the analysis and to ensure that relevant issues have been defined (p. 45).
Both constant comparison and theoretical sampling blur the traditional distinctions between data collecting and analysis and they involve the researcher in a dynamically interactive and iterative process as he or she moves to develop a rich and detailed grounded theory (Pidgeon, 1996).

Grounded Theory in Practice. Rennie et al (1988) commented in their review of grounded theory that this ‘approach does hold promise as a useful research strategy that could be broadly applied within the discipline of psychology’ (p. 148). In recent years, there has been a gradual growth of the use of grounded theory methods by psychological researchers in many diverse areas of the discipline. These include work in the area of health psychology (e.g. Charmaz, 1995), social psychology (e.g. Currie, 1988) and cognitive science (e.g. Pidgeon et al, 1991).

Within clinical psychology, researchers have utilised grounded theory approaches in areas as wide-ranging as the analysis of staff perspectives within the field of learning disabilities (Clegg, Standen & Jones, 1996), and counsellor's construal of success in psychotherapy sessions (Frontman & Kunkel, 1994). David Rennie in particular has advocated the usefulness of applying grounded theory methodology to psychotherapy process research and he has investigated areas such as, clients accounts of resistance in counselling sessions (Rennie, 1994), and client's experience of significant moments in psychotherapy sessions (Watson & Rennie, 1994).

Criticisms of Grounded Theory. The main criticisms of grounded theory seem to relate to the dichotomy between grounded theory as an epistemology and grounded theory as a method.

1) Epistemological criticisms. One criticism aimed at grounded theory is that it is apparent that some aspects of it are clearly based upon a positivistic epistemology (Pidgeon, 1996). Perhaps this is best typified by Glaser & Strauss's (1967) notion of
the 'discovery' of theory from the data. That is, an external reality exists that can be uncovered by the research process. This seems to contradict interactionist views as to the fluid and constructed nature of meaning (Pidgeon, 1996; Charmaz, 1995). Layder (1982) for example, is one author who has argued for the removal of grounded theory's empiricist conceptions of theory. Within the qualitative paradigm, this type of debate has been termed by Hammersley (1996) as the 'dilemma of qualitative method'.

This criticism also relates to the role of the researcher in grounded theory research and the need to encourage the researcher in the creative and interpretative process of generating theory. Although Glaser & Strauss's (1967) original version of grounded theory noted that 'the researcher does not approach reality as a tabula rasa' (p. 3), it did not adequately address the role of the researcher's theoretical background, relationship with respondents or the interactional construction of the data (Henwood & Pidgeon, 1992; Charmaz, 1995). Although later formulations of grounded theory by its developers have attempted to take account of these criticisms (e.g. Strauss & Corbin, 1994), some researchers have argued for a constructionist revision of grounded theory (e.g. Charmaz, 1990; Henwood & Pidgeon, 1995).

2) Methodological criticisms. An often cited criticism of grounded theory is that many instances of grounded theory research to date, have not developed theory from their data (Charmaz, 1995). At best, this research has provided rich conceptual analyses of people's experiences and social worlds, at worst they are merely redescriptions or glorified forms of content analysis (Stern, 1994; Charmaz, 1995; Pidgeon, 1996). This may be especially true for researchers new to grounded theory methods, who may only follow part of the analysis, or who adhere too strictly to Strauss & Corbin's (1990) framework of grounded theory so limiting theoretical development (Silverman, 1993). Constructionist revisions of grounded theory have alerted researchers to the fact that data should guide but not limit theorising (Layder, 1993).
Further criticisms of grounded theory have been aimed at more practical considerations, such as the type of data used and its analysis. Mauthner & Doucet (1997) for example, have commented on grounded theory’s emphasis on the sampling of events and incidents as a means to develop categories. Mauthner & Doucet argue that peoples’ actions and interactions are omitted in this process and therefore grounded theory seems to have less concern for the processes of reflection and decision-making than some other methods.

Practical criticisms have also been discussed by Rennie et al (1988). The authors argue that the reliance of grounded theory methods on verbal reports as data may pose a threat to the credibility of resulting theory. Participants may mislead researchers (consciously or unconsciously), and may misrepresent their internal processes. The use of the constant comparative method may increase credibility by demonstrating that individuals say similar things. Rennie et al (1988) also note that grounded theory research usually involves only a small number of participants. This may pose problems in terms of the generalizability of resulting theory as the arduous nature of the work can often limit the conduct of extensive comparative research. However, this issue may be accepted as the price to pay for detailed theory that is intimately tied to the phenomena it investigated.

Since its conception in the 1960s, Grounded Theory itself can be seen to be no longer a unitary concept. Even its originators, Glaser and Strauss have disagreed about each other’s description of grounded theory methodology (Stern, 1994; Rennie, 1998). Stern (1994) suggests that the Glaserian and Straussian methods should have different names: grounded theory for the Glaserian school, and conceptual description for the Straussian school. Rennie (1998) has outlined this debate in more detail, suggesting that the Straussian method has moved furthest away from the original version of grounded theory. This is typified by Strauss and Corbin’s 'Basics of Qualitative Research' (1990).
Criticisms aimed at the Straussian method, most notably by Glaser (1992) himself, suggest that the Straussian method has moved away from an inductive process to a deductive one, in which the resulting theory may not be as intimately tied to the data. In particular, Glaser criticises Strauss and Corbin's Paradigm Model, suggesting that this method may force the data in an attempt to uncover processes in the phenomenon under investigation. However, Corbin (1998) refutes the criticisms highlighted by Rennie's article, suggesting that although methods have to evolve and change over time, this does not necessarily reflect a fundamental change in view concerning the true essence of grounded theory.

A Constructionist Revision of Grounded Theory. Recently, within psychological research, some proponents of grounded theory methods have argued for and developed a constructionist revision of grounded theory (e.g. Charmaz, 1990; Layder, 1993; Henwood & Pidgeon, 1995). This attempts to capture more clearly the dynamic character of the research process and the role of the researcher in this. A particular proponent is Cathy Charmaz (1990). She has clarified how qualitative researchers must have a perspective from which they build their analyses. This 'researcher perspective' includes interests that guide questions asked in the research, philosophical stance, and the researcher's own experiences, priorities and values. In Charmaz's words 'I assume that the interaction between the researcher and the researched produces the data, and therefore the meanings that the researcher observes and defines' (p. 35).

Instead of Glaser & Strauss's (1967) notion of the 'discovery' of theory, the constructionist revision has sought to resolve this difficulty by referring to the 'generation' of theory (Pidgeon, 1996). The generation of theory has therefore been described as a constant interplay between data and conceptualisation, a 'flip-flop' between ideas and research experience (Bulmer, 1979; Henwood & Pidgeon, 1992). Henwood & Pidgeon (1992) discuss these ideas further by noting that the relationship between theory and data will at first be ill defined in the research process. By the researcher being able to tolerate and explore uncertainty, and to avoid premature
Interviewing as a Research Tool

Interviews have been described as 'a conversation with a purpose' (Dexter, 1970) and within research they are a frequently used means of gathering information. Within the quantitative research paradigm, interviewing has often been seen as an adjunct, or pilot phase of the research process (Henwood & Nicolson, 1995). However, in qualitative research, the interview is a frequently used method of gathering the main body of research information and there are several texts outlining appropriate guidelines for conducting ethical interviews (e.g. Erlandson et al, 1993; King, 1996). A role of the interview is to allow the researcher and participant to move back and forth in time, reconstructing the past and interpreting the present and future (Lincoln & Guba, 1985).

Depending upon the researcher's allegiances and research purpose, interviews and the information gathered from them will be viewed and treated in different ways. Silverman (1993) has discussed two main views on the role of the interview. A positivistic view may see interview data as giving us access to 'facts' about the world. With considerations of reliability and validity paramount, these types of interviews tend to follow a standardised protocol. This lack of flexibility in the interview enables direct comparability from one interview to another. However, critics of this approach stress an under emphasis on social interaction within interviews; and how both participant and interviewer can do 'different things with words and stories' (Maseide, 1990).

On the other hand, an interactionist view may see interviews as essentially concerned with symbolic interaction, with the social context of the interview an intrinsic part to the understanding of information collected (Silverman, 1993). Interviews may
therefore be more open-ended with no fixed sequence of questions and the interview process may be more flexible to discuss issues not listed on the schedule (Denzin, 1970). In-depth interviews, enabling a deeper understanding of the participant provides the basis for the validity of the research study (Reason & Rowan, 1981).
The Present Study - Participants

Six qualified clinical psychologists (5 females, 1 male) took part in this study. All the participants worked in Leicestershire, Derbyshire or Nottinghamshire and were all employed by the National Health Service. Five of the participants worked within clinical psychology departments, whilst one participant was employed in a psychotherapy department. The participants worked primarily with adults in the areas of primary care, physical health and general mental health services. The number of years since qualification ranged from one year to 18 years (mean = 7.83 years). The participants described working primarily within the following theoretical orientations: eclectic (n = 2), psychodynamic (n = 2), cognitive-behavioural (n = 1) and experiential models (n = 1).

The Researcher

At the time of writing, the researcher was a psychologist in her final year of a clinical psychology training course. To date, she has four and a half years of clinical experience and has worked in a variety of clinical settings within the National Health Service. The author practises mainly from a cognitive behavioural perspective, although this is informed by other theoretical orientations. The researcher was relatively inexperienced in terms of using a grounded theory approach prior to this study. However, in terms of other research experience, she has been involved in quantitative studies, both whilst training and prior to this (e.g. Choi & Tweed, 1996).

Researcher’s Epistemological Position. Henwood & Pidgeon (1994) have described the use of grounded theory methods as being encompassed within the general epistemological position of contextualism. That is, grounded theory concerns itself with the construction of intersubjective meaning (Henwood & Pidgeon, 1994; Henwood, 1997). However, different forms of grounded theory within this broad area have been described as taking alternative epistemological stances. For example,
Strauss & Corbin's (1990) version of grounded theory has been described as taking an empiricist and realist stance (Charmaz, 1995). As already discussed, recent revisions of grounded theory have emphasised an alternative, constructionist position (e.g. Charmaz, 1990; Layder, 1993; Henwood & Pidgeon, 1995).

In light of these debates, the epistemological position taken by the researcher in the present study was more closely allied to a constructionist position rather than a realist one. Therefore it was the aim of the study to elicit participants' interpretations of their experiences of non-attendance. Although Strauss & Corbin's (1990) version of grounded theory was mainly followed, as can be seen in the Procedure section, this is deviated from at certain points. For example, constructionist ideas advocating memo-writing as a means to highlight the researcher's role in the research process were incorporated into the method.

Researcher's Assumptions. As already discussed, theoretical sensitivity, as described by Strauss & Corbin (1990) is developed from several sources, including the literature, professional experience and personal experience. In terms of assumptions based on the literature, in preparation for the study, a literature search of the topic area was made. The relevant sources of material acquired through these searches provided the basis for developing a research proposal. The search also provided evidence that there was very little investigation of this area.

In terms of professional experience, the researcher's assumptions were also based on her encounters of client non-attendance. Therefore the researcher was aware of how she reacts to client non-attendance and her general policy of contacting the client by letter after non-attendance. Finally, the researcher was also intrigued to discover whether other therapists had similar experiences of client non-attendance. Her own experiences of client non-attendance therefore provided the impetus for the present study.
In recognition of issues of reflexivity, the researcher noted her expectations of the investigation in a field diary, prior to the commencement of interviews. During the research process, assumptions and observations concerning the study and experiences of conducting this type of research were regularly noted. These were also discussed with the project supervisor and within a qualitative research group, consisting of individuals at a similar stage in the research process. Although it is not possible to be aware of all internal processes pertaining to a topic (Rennie et al, 1988), by keeping the field diary, it enabled the researcher to gain some awareness of the role she played in the research process.

**Research Design**

This study employed a qualitative methodology, namely a grounded theory approach. A qualitative approach to this study was deemed the most appropriate method of inquiry for the reasons outlined in the Introduction section. Interview transcripts provided the raw data for the study, which were analysed using the grounded theory approach based mainly on Strauss & Corbin's (1990) version. As outlined in the previous section, this version of grounded theory has been criticised. The approach outlined in the following section demonstrates how some of these criticisms were taken into account.

**Procedure**

This section provides a detailed description of how the study was conducted. The section begins with the recruitment of participants, followed by the development of an interview guide, the interview procedure, and the procedure of data analysis. This section also draws on the literature to outline a procedure containing elements pertinent to producing research of good quality.
Recruitment of Participants. Ethical approval for the study was sought from the Leicestershire Health Ethics Committee. Approval for the study was granted on 8th November 1997 (see Appendix 1). All the participants were recruited by either the researcher or via colleagues. This demonstrates a pragmatic approach to sampling that may more accurately reflect the realities and constraints in designing a study of this nature. As McLeod (1996) suggests, many researchers using qualitative methodologies resort to this type of recruitment for similar reasons to this study e.g. time constraints. Prospective participants were asked if they wished to be interviewed for the present study. The aim of which was described as a ‘study to investigate clinical psychologists’ reactions to client non-attendance’.

Interview Guide. As already noted, there were very few research studies investigating the present topic of interest. Therefore, a semi-structured interview guide was developed from the researcher’s own experience of client non-attendance, in conjunction with discussion during supervision sessions. The guide aimed to be flexible, to facilitate participants’ expression of their thoughts and experiences, rather than to constrain them by adhering to a specific schedule. The interview guide aimed to seek participants’ constructions based on the following areas:

- Participants’ reaction to client non-attendance
- Departmental standard practices in relation to client non-attendance
- Whether participants sought supervision in relation to client non-attendance.
- The action participants took after non-attendance
- Participants’ views on factors that can influence non-attendance

A set of basic demographic questions were also asked of each participant:

- Time since qualification
- Area of clinical practice
- Whether the participant has undertaken post-qualification training
- Participants’ descriptions of the way in which they worked.
As already discussed, one aspect of the grounded theory approach is that the researcher is involved simultaneously in data collection and analysis. Therefore the data collection proceeded through successive stages according to what had been previously learned from initial data. The questions asked of participants changed in focus after the transcription and analysis of the first two interview transcripts. These accounts highlighted areas of interest relating to the gaining of clinical experience and the self-reflective process after non-attendance. Therefore included in later interviews were the questions:

- 'How has your reaction and response to client non-attendance changed over time since qualification?'
- 'How do you self-supervise after client non-attendance?'

**Interview Procedure.** On arrival at the participant's place of work, the aim of the interview was re-iterated and participants were given information on the estimated length of the interview and the confidentiality of data collected. The researcher sought agreement from the participant to tape-record the interview, and a consent form was signed (see Appendix 2). A copy of the consent form, detailing a contact telephone number for the researcher was given to the participant for his or her information (see Appendix 3).

The researcher then began the interview, most usually by beginning with the basic demographic questions to help put the participant at their ease. This was followed by one of the main questions detailed above. The researcher aimed to take a flexible approach to the interview and questions were not asked in a pre-set order. Any ambiguities in the participant's account were followed-up and attempts were made not to constrain the participant in their answers.

The interviews lasted from between forty-five minutes to one hour. After the interviews were completed, there was a brief general discussion as to the structure
and scope of the interview and the participant was asked to feedback their views. These were noted in the researcher's field diary (see Fig (1) for an example).

<table>
<thead>
<tr>
<th>5/12/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed interview with 'Sally'. I felt quite nervous about the interview beforehand, possibly because this was the third interview and the study was well and truly underway now. Felt the interview went ok, although I asked a confused question about experience and reactions to non-attendance. I was aware of trying not to lead Sally's responses in certain directions. At the end of the interview, Sally asked me if I had understood her responses. She reported being surprised that she could talk about client non-attendance for such a long time.</td>
</tr>
</tbody>
</table>

Figure 1. Example of post-interview note from researcher's field diary.

**Data Management.** The tape-recorded interviews were transcribed verbatim, in accordance to Strauss & Corbin's (1990) description, although verbal hesitations (e.g. erm, er) were not included. Pauses were indicated in the transcript, but were not timed. This is in contrast to a discourse analysis method for example, which would require very high levels of precise transcription. As a means to preserve the participant's anonymity, identifying material in the transcript was changed and each participant was given a pseudonym. This enabled the transcript to be ready for the process of grounded theory analysis.

The transcripts were not included in the appendix at the end of this thesis, but are part of a separate appendix (see Appendix 6).

**Grounded Theory Procedure.** The steps described in this section are mostly based on Strauss & Corbin's (1990) procedures and techniques. Charmaz (1995) and Rennie et al (1988) have also outlined procedures, and elements of these are also described as an adjunct to the Strauss & Corbin's method.
1) Open Coding. Open coding refers to the process concerned with naming and categorising phenomena through close examination of the data (Strauss & Corbin, 1990). Questions were asked of the data, such as ‘what is going on here?’, ‘what does this represent?’, to enable the development of concepts. A concept can be described as the verbal label placed on discrete happenings, events and actions. Similarly, to Rennie et al.’s (1988) suggestions, the transcripts were broken down into ‘meaning units’ of individual concepts, based on close reading of the interview texts. This enabled a close level of analysis of the transcripts so that the codes could be built from the ground upwards.

An example from the interview with ‘Kate’ is given below. A completed transcript coded at this level is also given in the Appendix (see Appendix 4). In the example below, verbatim material is presented in italics, followed by the participant’s pseudonym and the page and line number from the transcript.

“I do sometimes wonder (.) if they’re never there, you notice it more, just can’t be bothered to come and then it makes me feel a little bit cross that I’ve been doing the work for the whole group and they’re going to be missing’ (2, 55-58).

Here, concepts are identified such as Therapeutic Curiosity (‘I do sometimes wonder’), Hypothesising (‘just can’t be bothered to come’) and Negative Affective Reaction (‘makes me feel a little bit cross’).

As the analysis proceeded and the number of concepts increased, the researcher grouped together similar concepts and assessed which concepts made most sense to the phenomenon of client non-attendance. This process is known as categorizing’ (Strauss & Corbin, 1990). Categories were named, although at a more abstract level than the names given to concepts. The process of categorizing enables the researcher to identify gaps in the analysis (Charmaz, 1995).
As categories were produced and named they were developed in terms of their properties. These are the characteristics or attributes of a category. This enabled categories to be dimensionalized; that is, for its properties to be located upon a continuum. The development of properties and dimensions are important as they form the basis for making relationships between categories.

2) Axial Coding. This process involved further specification of categories by making connections between a category and its components (subcategories). Strauss & Corbin (1990) describe the method for relating subcategories to their categories as the Paradigm Model (p. 99). The authors suggest that a category is specified in terms of the Phenomena itself. This is the central idea to which a set of actions or interactions are directed at or related to. The discovery and specification of similarities and differences among and within categories can be described as one of the most crucial aspects of grounded theory.

In light of the criticisms aimed at the Paradigm Model (e.g. Glaser, 1992), it was noted that the model did lack flexibility concerning the analysis of participants’ accounts. Therefore the Paradigm Model was not adhered to as strictly as Strauss & Corbin (1990) suggest in their version. As a means to clarify relationships and processes within the categories in the present study, detailed definitions of each category were written in the researcher’s field diary. Charmaz (1995) and Pidgeon & Henwood (1997) have reported that this method is an important aspect of a grounded theory analysis.

During this process of further coding and definition, it became apparent that categories were becoming saturated. That is, analyses of additional data sets were revealing no new categories, properties, or relationships among them. Rennie et al (1988) have suggested that this occurs after the analysis of five to ten data sets.
3) Selective Coding and the Development of Theory. Selective coding is described as a similar process as axial coding, but analysis takes place at a more abstract level. Selective coding involved the selection of a Core Category, the central phenomenon around which all other categories were integrated. To assist with the integration process, Strauss & Corbin recommend the formulation of a 'story line'. This is a descriptive narrative about the central phenomenon. Categories were then grouped according to patterns developed during the analysis. Finally, the resulting account was grounded by validating it against the data.

4) Memo-Writing. Throughout the research process, memo-writing was a useful means by which the researcher kept track of her thoughts as data collection and analysis progressed. Memo-writing was used as part of the constant comparative method and helped to direct the form of the analysis. It also enabled the researcher to elaborate her internal processes and assumptions. By noting down ideas, the researcher was able to speculate about categories and the relationships between them. Memo-writing may be seen to be an intermediate step between coding and the first draft of the completed analysis (Charmaz, 1995). It is also seen as a means by which the researcher can consider his or her role in the research process. This is an element that critics of Strauss & Corbin's (1990) method have identified as under-emphasised in their work (e.g. Charmaz, 1990; Henwood & Pidgeon, 1995). An example of a memo is given below (Figure 2).

![Figure 2. Example of a memo from the researcher's field diary.](image-url)
Methods Used to Enhance Research Quality

The means by which the quality of qualitative research can be judged has fuelled debate within many of the social sciences. In recent years, researchers within psychology have also begun to tackle these issues (e.g. Henwood & Pidgeon, 1992; Stiles, 1993). It is generally felt that qualitative research cannot be adequately judged by the criteria and standards developed and utilised within quantitative research as these have different epistemological priorities and commitments (e.g. Henwood & Pidgeon, 1992). Examples of quality standards in quantitative research include internal and external reliability and validity and objectivity. These are generally felt to be the conventional benchmarks of scientific ‘rigor’ (Denzin & Lincoln, 1994). As yet, no firm criteria for assessing quality have yet been agreed in the community of qualitative researchers, as the following discussion will demonstrate. Also presented in this section are the methods used to enhance the research quality of the present study.

Validity. It has been suggested that in qualitative research emphasis has more usually been placed upon the concept of validity rather than the concept of reliability (Kirk & Miller, 1986). Validity relates to whether interpretations are internally consistent, useful, robust, generalisable or fruitful (Stiles, 1993). It refers to the degree to which what has been measured corresponds with other independent measures using other research tools (Parker, 1994). As already mentioned, there has been debate amongst qualitative researchers as to the appropriateness of applying the concept of validity to a different research paradigm (Smith, 1996). However, it is not doubted that qualitative research findings must demonstrate their ‘truth value’ (Erlandson et al, 1993). Two types of validity illustrate this point.

1) Respondent Validation. Basically, respondent validation involves the researcher taking his or her interpretations back to the participants who supplied the original material and seeking their views (Smith, 1996). Although useful and laudable, seeking the views of research participants is not without its problems. Stiles (1993)
has suggested that a participant may not understand aspects of him or herself and so may be unable to comment on interpretations made by the researcher. Overt respondent validation may only occur if the interpretations are compatible with the self-image of participants (Abrams, 1984). Participants may also be reluctant to disagree with the researcher concerning the interpretation of the research material due to the power relations that arise between researcher and participant (Smith, 1996). Respondent validation may be able to provide new avenues for further investigation, but needs to be employed cautiously and with awareness of its limitations.

Being aware of the cautions in using this particular method, in the present study, the participants were sent a summary of the initial findings from the data and asked to provide their comments (see Appendix 5 for summary). Three of the participants returned their comments within the specified time period. The researcher was aware that two participants were on personal-leave at the time of sending and so, would have been less likely to respond. However, the comments received acted to provide the author with alternative perspectives on the analysis.

2) Internal coherence. Basically, coherence can be directly assessed by the reader as the quality of the interpretation of the research. That is, does this study 'hang together?' (Stiles, 1993). Coherence includes internal consistency, providing an understandable explanation of the phenomenon under study, an awareness of rival interpretations and an ability to deal with loose ends (Stiles, 1993). Seeking other professionals’ views and comments on interpretations helps build the study’s credibility and can add to the internal coherence of the work (Erlandson et al, 1993).

As a means to achieve a greater level of internal coherence in the present study, the researcher attended data analysis meetings on a regular basis. The group included peers at the same level of training as the researcher and a group facilitator who was well versed in the use of qualitative methods. A description of one of these meetings is given as a typical example of the process of the group.
Prior to the meeting, peer group members exchanged brief excerpts from their interviews. Each member then coded and loosely categorised each excerpt. At the data analysis group, the excerpts were discussed in light of each member’s own interpretation and coding of the data. This enabled discrepancies and similarities between the codes to be highlighted. The data analysis meetings also provided peer support and help was available from the group facilitator concerning the finer details of analysis.

**Reliability.** In quantitative research the concept of reliability can be described as the extent to which the same results will be obtained if the research is repeated (Parker, 1994). That is, reliability is concerned with replicability. In qualitative research however, there has been debate as to how this can be achieved and indeed whether the concept of replicability is useful at all (Marshall & Rossman, 1989). However, it is generally accepted that an inquiry must provide its audience with evidence that if it were replicated with similar participants, in similar contexts, its findings would be repeated (Lincoln & Guba, 1985). Guba (1981) described this consistency in terms of ‘dependability’.

Silverman (1993) has described how the concept of reliability may be addressed in qualitative research. He cites Kirk & Miller (1986) as arguing that ‘for reliability to be calculated, it is incumbent on the scientific investigator to document his or her procedure’. Silverman suggests that emphasis should be placed on the standardisation of procedures, definitions and conventions throughout the research process. Consistency within the project is important to provide new researchers with a sound basis for similar studies. The present study has aimed to achieve this. The qualitative method itself does not guarantee reliability. This is achieved through serious effort on the part of the researcher (Peräkylä, 1997).
In summary, issues of reliability and validity in qualitative research broadly concern ‘trustworthiness’ (Guba, 1981; Lincoln & Guba, 1985). Reliability refers to the trustworthiness of observations or data and validity refers to the trustworthiness of interpretations or conclusions (Stiles, 1993). The methods described have presented ways in which the trustworthiness of the present study has aimed to be enhanced.

**Generalisation of Research Findings.** In the quantitative research paradigm it is usually a feature of the research that findings are generalised from the researched sample of cases to a wider population (Hammersley, 1996). In qualitative research, it has been suggested that researchers should talk in terms of ‘transferability’, rather than generalisability (Lincoln & Guba, 1985). This refers to applying the findings of a study to similar contexts from where they were first derived. The onus is therefore on other researchers to apply the findings to different contexts, rather than the original researcher having to ensure that their findings can be generalised to wider populations (Erlandson et al, 1993). Again, careful and detailed recording of research documentation and the contextual features of the study can ease the process of transferability (Henwood & Pidgeon, 1992).

By describing the research process in detail, it was the intention of the researcher to enhance reliability and generalisability, by enabling replication of this study, both with similar and different populations. However, it was accepted that the study could only be replicated in terms of the practical details of the procedure. Both the researcher and the participants will be different in any future study and this will have an impact on the analysis and conclusions reached.
ACCOUNT OF THE ANALYSIS

This section provides an account of the analysis. Firstly, the core category is described, followed by a description of the lower-level categories encompassed by this core category. Diagrams of the relationships between categories are provided in the text as a guide. For ease of reading, the main categories are denoted in capitalised bold lettering, intermediate level categories are denoted in capitalised lettering only and standard, non-capitalised lettering denotes sub-ordinate categories. Quotations given in the analysis also provide illustration to the categories described.

The main categories developed by the analysis have been identified in the interview texts of all the participants. Intermediate level categories have been identified in the texts of a least five of the participants and the sub-categories have been identified in the texts of at least two of the participants. Negative case examples are also presented as an illustration of where an account deviates from the main analysis.

Through analysis of the interview texts, one core category was identified. This is termed as Responsibility. Five main categories are also described that form a process model pertaining to client non-attendance. These include Being a Clinical Psychologist, Non-attendance, Experiencing Disruption as Affective Reaction, Re-Organisation to Equilibrium and Learning. An illustrated summary is provided in Figure 3. Arrows within the process model denote movement. These were derived from participants' accounts of decision points and processes occurring after the non-attendance events.

In terms of linkage between the core category and the process model, the core category can be seen to share many similarities to Being a Clinical Psychologist within the process model. Although similar, the core category is concerned with abstract concepts pertaining to participants' legal, moral and personal conduct and
sensibilities. This is seen to be a higher-order category than the process model, which is concerned with the practical day-to-day functioning of the participants.

Within the process model, main categories, intermediate level categories and subcategories are identified. These will be described later in this section. It will be seen that the analysis did not attempt to integrate group work into the process model. Although two of the participants also worked with clients within groups, the analysis focused on the phenomenon of client non-attendance for individual therapeutic work. It was assumed that parts of the process model would not be applicable to therapeutic work within group settings.
Fig 3. The core category and the process model
The Core Category: Responsibility

The core category identified in the analysis was termed Responsibility. There were three main areas where participants were seen to hold responsibility. These were to the Employer, the Client and Oneself. Non-attendance was described as having an impact on these three areas. This core category was also seen to have legal and moral aspects.

In terms of legal responsibility to the employer (within the National Health Service, the employing Health Trust), the participants were obliged to keep up-to-date accounts of client contacts and to work within the policies of the institution. By being accountable to their employer, the participants described the importance of being seen to be busy. There was a sense of obligation to the employer, to work to a high capacity in light of long waiting lists and increasing referral rates. Although non-attendance provided a useful opportunity to reduce workload, there was a concern that the client contact figures would not reflect to the employer the participant's true workload.

'We do report in our reports (...) you know actual attendances and planned attendances, so (...) we do make the point that you know, we do offer more appointments than are actually attended' ('Jan': 7, 213-216).

'I do feel an obligation to make use of the time (...) by doing something else, because there is no provision of (...) paying for non-attendance within the helping service' ('Peter': 2, 45-49).

However, the act of regularly accounting client contact figures did not sit comfortably with the participants.

'I often worry about my figures, so I might have an overall concern about you know my figures were down by this much this week' ('Carol': 16, 517-519).
'I just feel odd about the whole accounting thing, it's all nonsense really' ('Jan': 7, 217-218).

There was a general awareness concerning accountability within the National Health Service, especially in light of current government policies. The participants were aware of how non-attendance may be negatively construed by the institution.

'Well it's about accountability isn't it in state services? So schools are also having to be you know, looked at very closely and get black listed if you are, or even closed down with this government if your school isn't performing up to scratch. (...) We've probably been very privileged haven't we as a profession? Along with a lot of other state services in not having to account for what might be seen as treatment failures' ('Jan': 15, 482-489).

The participants also described a legal and moral responsibility towards their clients. For example, this may have entailed agreements on the assessment of a set number of clients in a week ('Louise': 2, 49-51). However, on a general level all the participants were employed to assess clients' needs and if appropriate, to intervene therapeutically. At a moral level, participants also described feeling responsible for aiding clients to recovery. Non-attendance acted to highlight to participants that they may have made a mistake, detrimental to the client.

'I will I think sometimes briefly think what did I do wrong, how come I haven't engaged this person?' ('Kate': 1, 25-26).

'There's also something about I'd really rather not think what I might be doing wrong thank you (...) but you know, having said that I think that actually we have a responsibility to them' ('Jan': 14, 461-464).

The category of Responsibility was also concerned with oneself. This was a responsibility to work to the best of one's ability, accepting one's strengths and limitations. Having standards for professional conduct was described as a means
by which participants guided their work. Although there was a desire to seek the reason for non-attendance, the participants described having certain lines that they would not cross.

'I feel quite strongly that it is important (,) to let people not come if they don't want to' (‘Kate’: 14, 458-459).

'Have I ever 'phoned anyone? As it were unsolicited? I don't think so (...) I feel it would be an impingement' (‘Jan’: 5, 162-166).

As can be seen, Responsibility as the core category encompasses several areas of clinical psychologists' experiences. Subsumed beneath this core category, a model pertaining to client non-attendance has been developed. This will be presented in the following section.
The Process Model

From the participants' descriptions of their experiences of non-attendance, a process model was developed (see Figure 3). The process model attempts to account for the effects of client non-attendance upon the participants and consists of five main areas. These are Being a Clinical Psychologist, Non-attendance, Experiencing Disruption as Affective Reaction, Re-organisation to Equilibrium and Learning. These will be discussed in the following sections. The process model suggests that movement occurs between these categories (denoted by arrows). However, the model is not able to fully represent the complexity of this movement and change and is therefore seen to be preliminary at this stage.

The model attempts to account for non-attendance of clients during the assessment and intervention stages of therapy. Although there is not a clear demarcation between assessment and intervention, for the scope of this analysis, the assessment stage is considered to involve mostly information gathering over the first or second appointments, whilst the intervention stage involves more goal-focused collaborative work based upon the theoretical orientations of the participants. This distinction was derived from the researchers' own experience of working therapeutically with clients on a time-limited basis, but was also based on descriptions contained in therapy-skills guides (e.g. Hawton, Salkovskis, Kirk & Clark, 1989; Lindsay & Powell, 1994).

By making a distinction between the two stages, this implies that the factors relevant to client non-attendance during assessment and intervention may be different. For example, some of the factors relevant to non-attendance are dependent upon whether the client had been seen previously. This may not be pertinent to non-attendance at the assessment stage of therapy.
Main Category – Being a Clinical Psychologist

From the analysis, a main category termed *Being a Clinical Psychologist* was identified. A diagram of this category is presented in Figure 4. As can be seen, this category consists of three intermediate level categories termed *Experience*, *Working Within Departmental Procedures* and *Working Within NHS Policies*. A brief description of the main category is given below, followed by a detailed description of the intermediate level categories and sub-categories shown in Figure 4.

This main category of *Being a Clinical Psychologist* encompasses the factors that form the participants’ identities, as qualified clinical psychologists working predominantly within the National Health Service. In terms of client non-attendance, the factors that form this category act as a mediator. How non-attendance is perceived, understood and acted upon is dependent upon the participants’ experience, having to work within departmental procedures and ultimately, having to work within NHS policies.

Negative Case – ‘Peter’ as dynamic psychotherapist

As already discussed, participants were sent a preliminary analysis for their comments. In ‘Peter’s’ response, he questioned the category of *Being a Clinical Psychologist* and the perception of his own identity as such. Although ‘Peter’ qualified as a clinical psychologist, he described his identity as a ‘dynamic psychotherapist’. Although ‘Peter’ did not elaborate on how this identity influenced the categories developed from the analysis, it may be speculated that he perceived non-attendance differently than the participants who did identify themselves as clinical psychologists. However, time constraints meant that ‘Peter’ was not re-contacted as a means of clarifying his point. Without more information, it would difficult to speculate where these differences might lie.
BEING A CLINICAL PSYCHOLOGIST

EXPERIENCE
- Therapy
- Non-Attendance
- Practice

WORKING WITHIN DEPARTMENTAL PROCEDURES
- Client
- Self

WORKING WITHIN NHS POLICIES
- Workload

Fig 4. Being a clinical psychologist
Intermediate level category - Experience

This intermediate level category was termed *Experience* and is split into six sub-categories. This category may be defined as the participants’ history. Throughout employment as clinical psychologists (and prior to this), the participants had been gaining experience, skills and knowledge. The participants had a wide range of clinical experience, ranging from one to eighteen years post-qualification and participants had also worked with a variety of client populations. Several factors formed the participants’ experience and these will be described as sub-categories later in this section. These factors formed a ‘database of experience’ that the participants accessed in order to make decisions and guide them through working life.

‘I’ve now started to realise because I’ve had enough experience of that now, that I can’t change that radically in ten minutes, so it’s not all about me’ (‘Carol’: 7, 202-205).

‘What I’ve learnt from experience is that yes, sometimes that will happen and then she simply doesn’t come’ (‘Jan’: 4, 116-117).

**Sub-Category - Client Experience.** This sub-category is particularly relevant where participants had worked with clients before the non-attendance event. The participants had acquired knowledge of their clients and in some instances had noticed that their clients had certain patterns of non-attendance.

‘I think there are some clients I can think of who may well retaliate after a break, with non-attendance’ (‘Peter’: 9,261-263).

This quote is interesting as it also highlights one possible role of the relationship between ‘Peter’ and some of his clients. In this excerpt, the term ‘retaliate’ has almost battle-like and confrontational connotations. It is possible that in response to the non-attendance of these clients, ‘Peter’s’ affective reaction will be related to the tone of his account.
Associated with having knowledge of the client, participants were also able to speculate upon their clients' reasons for non-attendance. This included reasons for non-attendance that were functional for the client and in fact, may have been used to have a particular impact upon the participants themselves.

'The not coming is her dealing partly with her anxiety, but also partly with her anger that I have let her down' ('Jan': 4, 118-120).

Irrespective of whether participants had seen clients previously, participants also described having some experience of the attendance patterns and behaviour of particular client groups.

'If it's a 'Rose Hill' [psychiatric unit] client, they tend to be more erratic attenders anyway' ('Carol': 3, 78-79).

'They tend to be people labelled as having personality disorders, so it tends to be that they find it harder to get to the session' ('Carol': 3, 88-90).

Sub-Category – Therapy Experience. Experience of therapeutic processes and techniques were identified as another factor that constituted the database of participants' experience. All the participants worked therapeutically with clients on a regular basis and all held active caseloads. Some of the participants described having specialised in a particular orientation of therapy and they had taken further qualifications and courses to enhance their skills in a model. In having knowledge of therapy, the participants knew that their therapeutic work could produce successful outcomes, even though the non-attendance of particular clients suggested this was not always the case.

'There have been other people with similar difficulties who have benefited from this kind of therapy and this person hasn't' ('Carol': 6, 197-199).
There was also an understanding and awareness of the dual nature of therapy. The quality of the therapeutic relationship was seen as an important part of whether clients engaged in therapeutic work. The first appointment was therefore seen as a crucial starting point in this process of engagement.

"Maybe if only they gave it a little bit of a try, they might get sort of hooked into it" ('Kate': 18,575-577).

"I think if they can get here once, that starts the process" ('Louise': 11, 319-320).

*Sub-Category – Experience of Non-Attendance.* All the participants encountered non-attendance on a fairly regular basis, especially non-attendance at first appointment. It was accepted that non-attendance would occur and it was described as a part of working life.

"And they happen so often, that it sort of is almost part of my everyday life" ('Louise': 6, 184-185).

Interestingly, one participant ('Kate') had no experience of a client dropping out of therapy during the intervention stage.

"I can't think of a time where they've stopped coming and that's been that for no reason" ('Kate': 3, 69-70).

It may be speculated that this is due to the relatively short period of time since her qualification.

Despite the rates of non-attendance, participants generally accepted that the client had a right to refuse assessment and treatment.
'She kind of dropped out of individual work, but I felt that I understood why she'd done that and in a sense that I respected that decision' ('Sally': 2, 46-48).

'I actually have an awful lot of people who at the end of a session will say, thanks very much but no thanks, and I actually think that that's a good thing' ('Kate': 15, 500-503).

However, this view was balanced by an awareness that for some clients, non-attendance was not a choice afforded to them. In particular, the participants had experience of working with clients in in-patient settings, where most usually the client would be visited by the clinical psychologist and would therefore find it difficult not to attend. In an extreme example, 'Jan' described how an in-patient she visited did find a dramatic method of opting out:

'We do some inpatient work of course, in the general hospital and we've got a captive patient there. They have to work very, very hard to drop out don't they? Although there was someone who simply wouldn't open her eyes. I went to see her and she made it quite clear that she didn't want to see me' ('Jan': 11, 365-369).

This suggests that one outcome of how inpatient referrals are made is that clients may feel less able to express their wishes. Resorting to more extreme means of expressing their views is seen as the only way to opt out of pre-arranged appointments.

Sub-Category – Self-Experience. Participants described being aware of their limitations and abilities in working therapeutically with clients. They tended to have a generally balanced view of their skills and in which circumstances they might best be utilised. It was accepted that having limitations led to participants being more vulnerable to blaming themselves for non-attendance.
'To do anything else does leave you more open to anxiety about yourself and if you’re connecting with people and what that feels like. And getting it wrong sometimes’ (‘Sally’: 10, 324-326).

‘I’ve been more able to say that I can help some people, but I can’t help others’ (‘Carol’: 6, 167-168).

However, as ‘Sally’ describes, being a fallible therapist is ultimately a more satisfying experience than being a ‘super technician’.

‘If you’re doing that then, from my perspective that would be a very unsatisfying, boring contact with people’ (‘Sally’: 10, 322-324).

Although, the participants were generally aware of their limitations, it was not particularly easy to discuss these with others or bring into the public domain.

‘I was interested that when you said, did you take it to supervision, it just made me think that no I don’t really, and it’s something that I will tend to wonder about on my own’ (‘Carol’: 18, 574-577).

As can be seen, this participant tended to deal with these issues on an individual basis.

Sub-Category – Experience of Practice. Two of the participants had experience of working as clinical psychologists in private practice. There was an awareness of how client non-attendance had a different impact if it occurred in private practice as opposed to National Health Service practice.

‘In private practice I would feel quite happy if someone doesn’t attend, or attends late, to sit there for the hour that I am contracted for and think about the person who is coming to see me’ (‘Peter’: 2, 40-43).

‘I guess if one’s to run a private clinic and they pay anyway, they’re obviously quite free to come and go aren’t they?’ (‘Jan’: 441-443).
Being directly contracted by the client to provide a service acted to remove those procedures specified by the employer, which contributed to participants' workloads. The accounts therefore contained a sense of freedom from workload pressures to spend exclusively on one particular client.

*Sub-Category – Knowledge of the Referral Route.* Working within particular departments, the participants had gained experience of the other professionals who referred clients to their services. The participants were able to identify referrers who made appropriate and inappropriate referrals. They had knowledge of how referrers prepared prospective clients for referral for psychological therapy and the quality and extent of this preparation. Participants were also aware that referrers could put pressure on clients to attend.

'The consultant would say, and I shall fit another appointment for you once I’ve had a report from the psychologist. So you can be a hundred percent sure really' (‘Kate’: 10, 329-331).

'I think GPs sometimes refer here and the clients aren’t that keen' (‘Louise: 9, 277-278).

It is not surprising then that the participants were able to make probabilistic predictions as to whether clients would attend for initial appointments, based purely on the name of the referrer.

*Summary of the Category of Experience*

Knowledge and experience in the areas described above were utilised to anticipate and even predict that a client would not attend. By having knowledge of the client (if seen previously), the referrer and the therapeutic relationship and process, the participants were able to use this information probabilistically to prepare themselves for the possibility of a client not attending.
'If they've had a really long wait then they don't tend to come. Also, young people don't tend to come to 'Rose Hill' [psychiatric unit], it's almost like a cut-off it's about age twenty-five and that's been quite startling' ('Carol': 16, 534-536).

Being able to anticipate non-attendance was not surprisingly, less effective for clients who were attending for an initial assessment. Having never met the client, the participants had only a brief outline of the client's presenting difficulties and knowledge of the referrer via whom the client was sent.

'Quite often people will still come back despite those signs, but they are sometimes an indicator' ('Louise': 8, 240-241).

'Quite often I will think this person definitely isn't gonna come back and they will turn up and engage really well' ('Kate': 4, 115-117).

The participants therefore accepted that prediction of non-attendance was a fallible and uncertain process.

Intermediate Level Category – Working Within Departmental Procedures

Procedures and guidelines for clinical practice in relation to non-attendance had been developed within each of the departments where the participants worked. Most usually, these procedures were not rigid and could be modified in light of participants' clinical judgement. All the participants described sending a standard letter to clients after non-attendance, asking them to contact within a time period if they wanted further appointments. This was most usually implemented after non-attendance at initial assessment.

'There's not anything that's rigid [department procedure]. What people tend to do is, they tend to write and do similar things to me (...) we'd write and say if you'd like a further appointment then please contact the
department within a certain time period, if not they will be discharged’ ('Carol': 4, 131-136).

Variations in departmental procedures included contacting the referrer after non-attendance at initial assessment, and having to do a set number of assessment interviews per week.

'We have procedures laid down about what we do if someone doesn’t attend an initial appointment. And we are all supposed to do a number of initial assessments every week' ('Louise': 2, 48-51).

In terms of reducing lengthy waiting lists and in an attempt to cut down on non-attendance at initial assessment, several participants described procedures for clients to ‘opt-in’ after referral. This usually involved prospective clients responding to a letter, asking them if they wished to be seen for assessment. In a similar vein, participants described procedures for sending clients information leaflets concerning the service, to enable them to make an informed choice about seeing a clinical psychologist.

'We would then have an opt-in procedure for the client who would need to return the form, even if you return the form blank' ('Peter': 10, 281-283).

'Jane' has been working on some information leaflets in a particular area of the service (...) so that we perhaps don’t get as many here, fail to attends' ('Jan': 8, 256-259).

As can be seen, departments specified certain procedures and guidelines in relation to client non-attendance, both as a response to the non-attendance event and as means of reducing client non-attendance at first appointment. Participants used their clinical judgement to determine to what extent these procedures were adhered to, as most usually, the procedures contained flexibility.
Intermediate Level Category – Working Within NHS Policies

The participants described the realities of working as clinical psychologists within the National Health Service. Most notably, there was an awareness and concern about the lengthy waiting lists for the services that the participants provided. There was a general atmosphere of time pressure and an expectation for the rapid throughput of clients. This was even reflected by the participant who provided longer-term psychotherapy:

[to the referrer] 'There's a couple of vacancies available. Can we look at who's on your list and prioritise who you want to send' ('Peter': 10, 292-293).

Non-attendance was therefore seen as problematic in terms of waiting-list management. If the client had cancelled their appointment, or not opted-in in the first place, another client could have been offered their session.

'But the reality is you know, there's a hundred people waiting on the list, many of them would have been glad of that slot if they didn't want it' ('Jan': 14, 443-445).

However, it was recognised that in aiming to reduce waiting lists, rather strict measures would have to be applied.

'We don't tend to offer automatically second appointments if people don't attend the first one, because people are so clogged up' ('Louise': 4, 113-115).

'I don't give many chances I suppose. (...) I'm not saying that because I think therapeutically that's a good thing, I'm saying it just because that's what I do and I think it is actually a response to being very pressured, with very long lists' ('Jan': 4, 99-101).
As the excerpts suggest, these measures were seen to not necessarily be in the clients’ best interests.

Sub-Category – Workload. Both the intermediate level categories above (Working within departmental procedures; Working within NHS policies) contributed to the participants’ workload. Administration procedures had to be followed which tended to produce a fairly high level of paperwork. As already mentioned, participants were generally faced with long waiting lists and in some cases had to fulfil a quota of a number of assessment interviews in a week. These factors all contributed to maintaining workload levels. It was not surprising then, that client non-attendance tended to provide an opportunity for participants to employ this time catching up on administration paperwork.

‘Sometimes people cancel and then that’s real relief because I know that everything is ok and I can catch up on paperwork’ (‘Louise’: 1, 27-28).

‘I don’t do much hanging around really. So mainly I wouldn’t even be at the stage of sitting around waiting [for client to attend]. I’d be in the middle of something’ (‘Jan’: 12, 389-391).

The excerpts provide an illustration of the usefulness of certain non-attendance events to participants. As can be seen, participants were able to direct their attention to other workload commitments in an attempt to manage these administration procedures.
Main Category – Non-Attendance

This was defined as a therapy event where the client does not attend for their arranged appointment and has not contacted the clinical psychologist to cancel their appointment beforehand. As already mentioned, in some cases the participants had anticipated or even predicted this event. In other cases, the event had not been predicted and was therefore unexpected. However, at some level, the participants had prepared themselves for the scheduled session. The client’s non-attendance therefore provided the participants with an empty session slot.

‘If I was anticipating a difficult session, I might start to feel a bit of relief that they haven’t come’ (‘Carol’: 12, 376-378).

Non-attendance caused disruption to the session slot, as the time was no longer allocated for the purpose the participants had intended. As the next section discusses, the non-attendance event also provoked disorganisation and disruption within participants themselves.
Main Category – Experiencing Disruption as Affective Reaction

The next main category identified within the process model was termed Experiencing Disruption as Affective Reaction. Participants described their reaction to client non-attendance as being initially felt at an affective level. That is, the disorganisation of the non-attendance event evoked an emotional response of some kind. How this was perceived was dependent upon the mediating factors identified in the section Being a Clinical Psychologist. Figure 5 provides a summary of this category. As can be seen, the main category is split into three intermediate level categories. These are termed State of Flux, Realisation and Noticing Affect. Within the Noticing Affect category, two sub-categories were identified, termed positive and negative.

From participants’ descriptions, it is hypothesised that every non-attendance event will produce an affective reaction. However, the strength and nature of this reaction will vary, depending upon a variety of factors.
Fig 5. Experiencing disruption as affective reaction
Intermediate Level Category – State of Flux

Participants described being in a state of flux at the beginning of the session slot. Not having heard anything to the contrary, the participants would be expecting the client to arrive. Even if participants had anticipated that the client would not attend, their previous experience would tell them that this feeling was not always accurate. There was a sense of agitation as the participants were trapped in the uncertainty of the situation. This sense of agitation is typified in the ‘Peter’ interview:

‘The first minute I would think ask reception, they haven’t noticed and then haven’t rung, so I would usually go and check. And if the client wasn’t there then I’d start thinking on the way up. I might then think about well that’s useful, that’s X,Y,Z I had to do. Shall I do it now? Or shall I give it a bit more time?’ (‘Peter’: 12, 348-352).

The length of time participants spent expecting the client to arrive depended upon previous experience of that client (if they had any). If the client consistently attended early, then the expectation for the client to arrive may have only lasted until the first few minutes of the session. Alternatively, if clients regularly attended late, this feeling of expectation lasted longer.

‘If it is at that point [ten minutes into the session] I would just be wondering whether they were or weren’t going to come, and people, some people attend routinely late’ (‘Louise’: 11, 328-330).

‘There are some clients where I’ll think, I’ll give it forty-five minutes. (...) And then there are others where I’ll think if they aren’t here ten minutes early, they are unlikely to turn up today’ (‘Peter’: 12, 361-365).

Most usually, participants would be waiting for clients to attend in their offices or consulting room, where it is a relatively simple matter to direct one’s attention to other tasks whilst waiting. However, the time the participants spent in a state of
flux also depended on the location the participant was in and whether they had brought other tasks to do if the client did not attend.

'Sometimes I go somewhere else to see people, so for example I might literally be at say a hospital to see one person. And then there's always the issue for me of how long do I wait before I go away and do something? Because I haven't got anything there to do' (Jan: 13, 405-409).

As can be seen, several factors mediated this category, including participants' experience of non-attendance events and knowledge of their clients. Similarly, the location of the scheduled appointment also had an impact on participants' response to non-attendance.

 Intermediate Level Category – Realisation

The participants described a time when they would realise that the client was not going to attend, or was unlikely to attend. For some of the participants, time was the factor by which they would realise that a client was not attending.

'Now when it gets to ten past, I think right they're not coming' (Kate: 12, 394-395).

'If it's not their usual behaviour, you know some people are obviously half an hour early, so at ten past one, I'd know' (Louise: 11, 331-333).

For other participants, the onset of the realisation process would be more gradual.

'After that there comes a point ah but {laughs}. Actually they haven't turned up' (Sally: 11, 350-351).

As for the previous category, this process of realisation depended upon the participants’ experience and knowledge of the client, if this was available.
Intermediate Level Category – Noticing Affect

At some point during the planned-for session, participants described experiencing an affective reaction in response to the client’s non-attendance.

‘I’ll notice an emotional reaction to it, you know depending on the client’ (‘Peter’: 12, 355-356).

The types of affective reactions described by the participants are discussed later in this section, but in summary have been split into two sub-categories: positive and negative. The reactions do not necessarily occur separately, so for example, participants described being relieved (Positive Affect) as an initial affective reaction, which then changed to worry (Negative Affect) (see for example ‘Carol’: 12, 376-382).

Sub-Category – Positive Affect. On some occasions after client non-attendance, participants described experiencing a positive affective reaction. This was mediated by knowledge of the client and the participants’ current workload. Most usually, the reaction described was one of relief, especially if the participants needed extra time to complete paperwork and administration tasks.

‘If it is someone who I know is doing fine and just appears to have not turned up, then it’s relief’ (‘Louise’: 1, 29-30).

‘There is also the feeling for me of relief, you know, have some extra time that I didn’t budget for and which is a bit of a gift’ (‘Peter’: 3, 72-74).

Participants’ accounts of experiencing a positive reaction to non-attendance contained humour. This suggests an almost celebratory response to some non-attendance events.
'It depends how busy I've been during the day. Sometimes I think oh way-hay {laughs}, I can go and put my feet up' ('Kate': 11, 368-370).

[first reaction to non-attendance] 'Good admin time {laughs}' ('Sally': 11, 345).

However, by using humour in their accounts in this way, it may also be suggested that participants were defending themselves against experiencing negative affective responses to the non-attendance event. The types of negative affect experienced are discussed in the following section.

**Sub-Category – Negative Affect.** As described in the previous section, a positive affective response (usually relief) was often participants' initial reaction to non-attendance, especially if they had a high workload. However, participants did describe experiencing negative affective reactions after non-attendance.

1) Anxiety. Worry and concern about the client were described as the most typical negative affective reactions. Knowledge and experience of the client mediated this sub-category, in particular participants experienced this reaction if they had built therapeutic relationships with their clients. Non-attendance during the intervention stage was therefore seen to have a greater impact upon the participants than non-attendance during the assessment stage.

'So there's some clients who are regular attenders and if they don't turn up and if they don't leave a message or send a message, they will be cause for concern' ('Peter': 1, 22-24).

'The power of the relationship is very striking really. If I haven't got a face to put [to] it I'm kind of, not get so entrenched in having the worry and concern about it' ('Louise': 14, 430-433).

Often associated with experiencing worry and concern, participants also described wondering about the clients' fate. This was especially pertinent if participants had knowledge of their clients and assessed or believed that they were at risk. Most
usually, these feelings concerned a fear that clients had committed suicide or had physically harmed themselves.

'I guess the first time she dna'd [did not attend] I would have thought oh hell, I don't know if she is a rotting corpse somewhere' ('Jan': 6, 200-201).

'I was worried that she had harmed herself, either deliberately or not' ('Sally': 3, 78-80).

2) Anger. Although concern and worry were described as the most typical negative affective reactions to non-attendance, other negative reactions were discussed. These included feelings such as anger and irritation that the client had not attended and hadn’t cancelled beforehand. This suggests that participants prepared for the sessions and perceived that their preparation time had been wasted. This is perhaps most clearly seen in ‘Jan’s’ response to the researcher’s letter asking for comments on an initial account of the analysis.

'I write this to you during a non-attendance (at 5.20 p.m. and after the patient has 'opted-in') so have a chance to reflect on my state! My primary affect is anger at the client 'how dare she waste my time?' and also at referrer 'was probably an inappropriate referral' etc. and am resolved to close the case – no 2nd chance at this stage!!' Respondent Validation: ‘Jan’.

It is also suggested that participants’ anger and irritation at client non-attendance reflected their expectation of ‘normal’ protocols within the therapeutic setting. That is, clients should inform their therapists that they are unable or unwilling to attend and they should adhere to these rules of courtesy.

'It is very rude, to simply not turn up' ('Jan': 2, 40).

'I do sometimes feel it's impolite for them not to ring and say they're not going to come' ('Kate': 15, 473-475).
3) Sadness. Occasionally, sadness and disappointment were described. This was generally in response to the non-attendance of clients for whom it was felt there was a positive therapeutic relationship.

'And then when she didn't turn up I felt sad, 'cos quite often I might feel relieved, you know if it was a difficult client, but I felt sad really' ('Carol': 8, 255-258).

'Then if they don't come back I guess that's you know, that's a sense of a kind of lost opportunity, that's a shame you know' ('Sally': 8, 242-244).

4) Self-Blame. Without knowing why clients had failed to attend, participants described experiencing feelings of self-blame. This occurred when participants had seen clients on at least one previous occasion and a therapeutic relationship had begun to be built.

"I will I think sometimes briefly think what did I do wrong? How come I haven't engaged this person?" ('Kate': 1, 25-26).

'You know was there some failing in me, that they are reacting to?' ('Jan': 2, 51-52).

Negative Case – Self-Blame at Initial Attendance. However, a negative case example illustrates that even without having seen the client, self-blame may still occur. Although the participant logically appreciates that clients are not reacting to any mistake she might have made, on an emotional level self-blame is still experienced. Her experience of self-blame was dependent upon having had several clients not attending for their initial assessment appointments in a short time period.

'People that don't turn up at all, but that feels ok unless I've had a number of people that don't turn up for their first session over a week or two weeks. (...) Then I'll start to attribute it to myself, and I know that
logically that it can't be attributable to me really, but I start to worry about whether there's something about my reputation that's got out somewhere (...) like in the local press or something' ('Carol': 2, 41-47).

Perhaps this account also reflects the influence of unresolved personal issues in the participant's reaction to the non-attendance event.

Summary

In reaction to the session not proceeding as planned, participants described experiencing this disorganisation in terms of affective responses. Generally, a greater level of affective response (and more usually negative) occurred when clients did not attend during the intervention stage of therapy. Non-attendance during intervention tended to have a more fundamental impact on the participants and affected their self-view. This is evidenced by the self-blaming reactions triggered by non-attendance in which the participants were concerned that they had done something wrong. This suggested that the participants had invested themselves into the therapeutic process and non-attendance was seen to be a breach to the therapeutic relationship.
Main Category – Re-Organisation to Equilibrium

The next main category identified in the process model was termed *Re-organisation to Equilibrium*. Here, as a response to the disorganisation and disruption to the session-as-planned, participants engaged in *Self Supervision* as a means of considering and deciding upon certain strategies to reduce the disruption of the event. These were aimed at re-organising the disruption of the event back to equilibrium. Participants employed a variety of strategies and several strategies were used together. *Figure 6* provides a summary of the categories. As can be seen from *Figure 6*, five main strategies are presented as intermediate level categories. These are termed *Therapeutic Curiosity, Attributing Responsibility, Deciding on External Supervision, Considering Client Directed Action* and *Considering Use of Space*.

The five intermediate level categories presented all represent types of self-supervisory processes. However, subsumed within the categories of *Deciding on External Supervision, Considering Client Directed Action* and *Considering Use of Space*, several activities are described. It is at this point that self-supervision can be seen to transform into *External Action*. Each category is described in more detail in the following sections.
Fig 6 Re-organisation to equilibrium
Intermediate Level Category – Self-Supervision

Self-supervision was described as a process whereby re-organisation strategies were considered and decided upon. As will be discussed, self-supervision was made up of several elements. These included *Therapeutic Curiosity; Attributing Responsibility; Deciding on External Supervision; Considering Client-Directed Action and Considering Use of Session Space*. Most usually, self-supervision took place during the session space made available by the non-attendance event and generally was not seen as a qualitatively different process to the one the participants engaged in concerning ongoing clients. The self-supervision process was often termed by the participants as a ‘space to reflect’ and it was felt to be important that participants were able to create time for this process.

‘*I make reflective space. Which is no different from anything else that crops up in therapy*’ (‘*Peter*’: 5, 144-146).

‘*All I guess I would do is what I would usually do following a session or a non-session, which is wonder about what had happened, see what sense I made of it and what I thought I needed to do*’ (‘*Louise*’: 6, 155-158).

This was seen as especially pertinent if the non-attendance had been of clients who were at the intervention stage in therapy.

Intermediate-Level Category – Therapeutic Curiosity

Participants described feeling a need to know why the client had failed to attend. This category was mediated by experience of the client. Non-attendance at first appointment did not generally lead to as great a need for answers as non-attendance during the intervention stage. Even if participants had anticipated clients’ non-attendance, it was not known whether the causal reasons speculated upon were accurate. If non-attendance was an unexpected event and acted to surprise participants, the desire to find out what had happened was usually greater.
'When it’s someone that you have a meeting regularly, there’s much more of a personal wanting to know and wanting to check out' (‘Louise’: 15, 435-437).

'It happened with a client not too long ago, so my reaction was one of, I wonder what is going on?’ (‘Peter’: 1, 25-27).

However, there seemed an acceptance in the participants’ accounts that with some non-attendance events they would never know why the client failed to attend.

'So when somebody just stops coming, you actually don’t have any access to what’s happened’ (‘Sally’: 2, 57-58).

'[non-attendance] probably is a reflection of something going on in the therapy. And can be usefully used. If and when the client returns’ (‘Louise’: 7,197-199). [my emphasis]

The accounts reflected an underlying tension between wanting to know the reasons for non-attendance, but not wanting to impinge upon clients’ freedom of choice.

'They [clients] don’t have to ring me and say I don’t want to come’. (...) ‘If they did have to ring and say alright you know, I don’t want to come, it would give us a chance to see if we could find out what the reasons behind that were. And that would be useful’ (‘Kate’: 13, 431-433; 13, 438-441).

In terms of specific strategies used to seek answers, these depended upon the participants’ knowledge of their clients. The next sub-sections describe these categories in more detail.

Sub-Category – Accessing the Database of Experience. This involved hypothesising about the possible reasons for non-attendance, based on experience and knowledge of the factors that can exert an influence on non-attendance. This strategy was generally used when participants had a limited knowledge of their
clients. Participants were able to speculate about the non-attendance event, using factors from their own personal experience of non-attendance and their knowledge of relevant research. This involved making hypotheses about client factors (client-directed reflection), relationship factors (reflection on the interaction) and factors concerning coming to see a clinical psychologist (analysis of clinical skills). This aided an understanding of why clients were unable or unwilling to attend.

'In my experience it [non-attendance] has often been because people have gone elsewhere or the crisis has passed' ('Louise': 3, 84-86).

'It might be things like expectations. They might think it's going to be a magical cure, or it might be a very quick cure and then that doesn't happen and they feel disappointed' ('Carol': 7, 212-214).

Sub-Category – Reflecting on the Previous Session. This strategy could only be employed if participants had seen their clients prior to the non-attendance event. Participants described thinking back over the last session the client attended, seeking clues within it as to why the client failed to attend subsequently. This included looking for specific events which may have caused or contributed to non-attendance, but also included a general perception of the success of the session as a whole.

'Well I suppose some break down in you know, what one might loosely call the alliance, so if it's something about generally feeling the session didn't go well' ('Jan': 3, 66-68).

However, this was not always a fruitful enterprise if reflection on the previous session failed to find any events that seem relevant:

'I felt we were doing very good work, there wasn't anything I could see leading up to it, you know in the session before' ('Sally': 3, 68-70).
Reflecting on the previous session involved different types of analysis, which are discussed below.

1) Client-Directed Reflection. This involved participants' reflecting on the previous session, but looking specifically for client-based factors which could partly or wholly explain the subsequent non-attendance. This involved reflecting upon clients' verbalisations, in particular negative statements concerning the session.

'It would be difficult to describe what it is I've picked up in those people. I suppose it's absolute adamant, blanking that you know, you know I didn't wanna be here' ('Kate': 18, 587-590).

Participants may make an assessment of clients' affective state in the session before non-attendance as a possible influencing factor. This usually involved assessment of negative affect, such as anger or distress.

'I might think about how they were when they left the room as well, did they still feel upset, had it not been sort of put back in the box again? I might think about whether they seemed a bit angry' ('Carol': 9, 298-301).

As a means of reflecting upon the previous session from the clients' point of view, participants described a method that was categorised and termed within the analysis as 'empathic speculation'. This involved participants taking on their clients' perspective, and considering the possible impact of the session.

'I'll be thinking you might have had an awful experience of me and they might not want to come back' ('Carol': 4, 125-127).

'I quite clearly felt, well look you know, I've got degenerative disease of the spine and this consultant's wanting me to go along and see this stupid psychologist. I really don't want to go, it's quite clearly in my back' ('Kate': 15, 491-494).
2) Reflection on the Interaction. Participants described reflecting upon the quality of the relationship they had with their clients in the previous sessions. In psychodynamic terms, this would include considering the issues of transference and countertransference.

'If we can’t locate it either in me or in them, is it something that’s going on between us?' (‘Jan’: 2, 55-57).

'I think that some patients will pick up if I’m under too much pressure and will start unconsciously protecting me by missing appointments' (‘Peter’: 3, 74-76).

3) Analysis of Clinical Skills. As a means to examine possible reasons why clients failed to attend, participants described reflecting upon their own clinical skills in the session space made available by the non-attendance event. In particular, participants described looking for errors they might have made in previous sessions that could have contributed to the non-attendance. This included looking for errors where participants had not done enough (e.g. lack of empathy), or errors where participants had done too much (e.g. rushing ahead).

'So for me it’s kind of questions about well, did was there something I did, or said, did I push the client too hard, did I not listen? You know, was there some failing in me that they are reacting to?' (‘Jan’: 2, 49-52).

'I wonder whether I’ve not told them enough about what to expect. I wonder whether I might have pushed them too far with new information' (‘Carol’: 2, 53-55).

'I might feel that I’m a lousy therapist, an incompetent therapist, that I’ve not been empathic enough' (‘Carol’: 5, 144-146).
As the quotations illustrate, this strategy tended to be associated with feelings of self-blame.

Intermediate Level Category – Attributing Responsibility

As part of the process of internal supervision, participants described attempting to attribute responsibility for the non-attendance event. This strategy was employed most usually after participants had experienced feelings of self-blame for the non-attendance. Participants described using this strategy not only in instances where participants had seen clients on previous occasions, but also if self-blame had been experienced after non-attendance at an initial appointment. Attributing responsibility was seen to fall into two areas: Accepting Responsibility and Re-attribution of Responsibility.

'Since I was first qualified when I took every drop out as a (...) reflection on my personal skills as a therapist and I think it's right to do that to some extent. But not to you know, not to always assume that that's what's happened' ('Sally': 4, 119-123). [my emphasis]

'I feel better able to say that perhaps it's not the right time for somebody, or that this kind of therapy isn't what they need at the moment and perhaps to change the type of therapy, or that just therapy isn't helpful for them. So it's less about me, perhaps more about the therapy' ('Carol': 6, 189-194).

Sub-Category – Accepting Responsibility. Participants were able to accept responsibility for contributing to, or directly causing non-attendance events for clients who had been seen previously. Accepting responsibility related to participants being aware of their limitations and accepting that they are unable to work successfully with every client referred.
'I have known some people who I just thought god I can't relate to you at all, and I don't like you, which doesn't bode well' ('Jan': 11, 343-345).

'I don't doubt that sometimes people drop out because I have been unable to find a useful way of relating to them, or where it has been about me' ('Sally': 5, 153-156).

As already discussed, being aware of one's limitations was one factor that contributed to the categories of Experience, and Being a Clinical Psychologist.

Sub-Category – Re-Attribution of Responsibility. Participants described re-attributing the responsibility for the non-attendance event. This also included instances where the clients had never attended for appointments. The re-attribution of responsibility was seen as having a protective function for the participants. Although participants were generally able to accept their limitations and mistakes, by re-attributing responsibility, they could relieve their anxiety about being solely to blame for the non-attendance. Several methods of re-attributing responsibility are discussed below. There was little evidence participants' excessively re-attributed responsibility away from themselves.

One participant's account ('Peter') in fact, did not contain any examples of using this strategy at all (Negative Case). This seems to relate to 'Peter' not describing self-blame as an affective reaction to non-attendance. However, there may also be a suggestion that 'Peter' was unable to express experiencing self-blame for personal reasons or reasons associated with the interview process itself.

1) Use of Logic. This was especially pertinent if participants had never met clients previously, although still blamed themselves for the non-attendance.

'People that don’t turn up at all, but that feels ok unless I've had a number of people that don’t turn up for their first session over a week or two weeks. Then I'll start to attribute it to myself, and I know logically that it can't be attributable to me really' (Carol': 2, 44-47).
‘There’s actually quite a lot of people who don’t turn up in the first place. Again clearly I can’t attribute that to being me failing in any way’ (‘Kate’: 20, 664-666).

2) Consideration of Other Causal Factors. This type of re-attribution is based upon participants’ experience of factors that can influence attendance. By considering possible factors that can contribute to non-attendance and by having knowledge of the client, a likely reason could be speculated upon.

‘The way that one of them [referrer] is putting it at the moment of you know, they’re not really given any choice, they either come or they don’t get to see the surgeon again’ (‘Kate’: 19, 608-611). (Referrer Responsibility).

‘I think I, in my own mind to be honest, quite honest, I would make a quick judgement I think about whether it was a dna [did not attend] because someone is just scatty’ (‘Sally’: 11, 356-358). (Client Responsibility).

‘There is no facility here for childcare, many, particularly single parent families, it’s impossible for them to come along with no one to leave the children with’ (‘Louise’: 10, 285-288). (Practical Problems).

3) Analysis of Success. Participants described reflecting upon their positive and successful actions in the previous session as a means of re-attributing responsibility.

‘I like to think that I am going over the fact that I did give them plenty of opportunity to say what they wanted’ (‘Kate’: 4, 99-101).

This also involved considering previous therapeutic successes. These acted as an anchor-point by which current non-attendance events could be assessed. Re-
attribution of responsibility was aided as participants realised they had achieved positive outcomes in the past.

'It's only through my own experience of knowing that I can help people and that there are loads and loads of people on the waiting list. If I can't help that person then there might be someone else that I can help' ('Carol': 19, 620-623).

This contributed to participants' confidence that they could work successfully.

Intermediate Level Category – Deciding on External Supervision

As part of the process of self-supervision, participants described making a decision to seek external supervision and to talk to someone else about the non-attendance event. This decision was not made for every non-attendance event, but those that were most usually associated with a negative affective response such as worry and concern. The exception to this was when clients adhered to a model of supervision by which all clients were 'checked in' irrespective of whether they were a cause for concern (see 'Peter': 6, 157-162). Also, the decision to seek external supervision generally occurred for clients whom participants had seen on previous occasions and were at the intervention stage of therapy.

'I need to think about what's happened here and to decide either just to send them a letter or to take that to supervision, I guess about what's happened' ('Sally': 11, 367-370).

'So if I am concerned about a client who hasn't attended or if something comes up as a result of it, then I will take it to supervision' ('Louise: 7, 213-215).

As can be seen in Figure 6, the decision to seek external supervision led to External Action. That is, participants were no longer engaged in a self-reflexive
process, but have opted to move outside the self and to seek consultation from an external source.

Sub-Category – **Formal Supervision.** Participants described deciding to seek external supervision on a formal basis. That is discussing the non-attendance event in a setting specific to the purpose of supervision. Formal supervision may be on an individual basis, with the supervisor as a more senior clinical psychologist than the participants themselves or, supervision may be held with similarly experienced peers. Formal supervision acted as a forum whereby participants’ reactions and thoughts concerning client non-attendance could be expressed and discussed. These included difficult emotional reactions experienced after non-attendance.

> ‘I might bring it up in peer supervision if I think that there is a large element of my own contribution to this. If I think that a patient is special for one particular reason, or has become special. Or if I find myself with an unusual reaction’ (‘Peter’: 6, 167-170).

> ‘You know supervision is very important if you’ve got a case where, you know you’re really not feeling like you are connecting, or understanding or whatever, and you see you’ve had supervision and it’s like oh right ok, so that was what was going on’ (‘Sally’: 8, 237-241).

Supervision was seen as a means by which new understandings could be reached and possible further action decided upon.

**Negative Case – Not Discussing Non-attendance in Formal Supervision.** One participant described finding it difficult to discuss non-attendance in formal supervision. As a result, she only discussed it very infrequently. The reason for this reluctance seemed to be feeling ashamed that non-attendance would indicate to others that there had been failure on her part to engage clients. Although most of the participants had expressed finding the discussion of non-attendance in formal supervision to be useful, this particular participant did not.
'I was interested that when you said did you take it to supervision, it just made me think that no I don’t really and it’s something that I will tend to wonder about on my own' ('Carol': 18, 574-577).

'I realise that I felt a bit ashamed of me (...) I thought well this is actually quite hard to say that somebody came for therapy and then dropped out. I realise that I do feel quite bad about it' ('Carol': 18, 580-583).

Possible Sub-Category – Informal Supervision. Seeking informal supervision was the means by which this participant discussed client non-attendance away from the specific and arranged setting of formal supervision. Informal supervision in this context acted to aid re-attribution of the participant’s feelings of self-blame about the non-attendance events.

'It might be that I’ve had a run of people not turning up this week, other people might say yeah, I’ve had that as well and then I can attribute it to something else, like it’s the weather or the clocks going back' ('Carol': 11, 361-365).

It is not clear whether the other participants discussed non-attendance informally with colleagues, as this was an area not specifically addressed in the interviews. However, if this were the case, Informal Supervision could be created into a sub-category alongside Formal Supervision.

Intermediate Level Category – Considering Client-Directed Action

Another aspect of the internal supervision process included the consideration of client-directed action. Participants described reflecting upon what they needed to do in relation to the non-attendance event. This included action that was directly reactive to the particular client. For example, participants described writing letters to clients, contacting other professionals who had knowledge of the non-attending clients and discharging clients from participants’ caseloads. Indirect
measures were also described which involved attempting to reduce client non-attendance rates in the future. These strategies will be discussed in the following sub-sections.

'And deciding what, what I was going to do if they didn't attend, you know whether I was going to write a letter, or was I going to contact them' ('Louise': 11, 336-338).

As in the previous intermediate level category described, this process of self-supervision led to External Action.

**Sub-Category — Contact Client Directly.** After non-attendance, the participants described contacting every client. The means and type of contact was dependent upon the participants’ knowledge of the client and the participants’ own standards of practice. Departmental procedures also had an influence on the type and content of the correspondence. The various types of correspondence are presented below.

1) Sending a ‘Standard’ Letter. ‘Standard’ letters were sent to the majority of clients after non-attendance and most often if they had not attended during the assessment stage. Participants described standard letters as a basic correspondence to clients, whereby they were reminded that they had missed their appointment and were given a deadline to contact the participant to arrange another. If the deadline passed without any contact, clients were informed that they would be discharged from the participants’ caseloads. The sending of standard letters had often become part of a departmental procedure.

This strategy was seen as useful for participants, especially if they had high workloads. It enabled them to leave the decision for re-contacting the service in the hands of clients. If they did not receive any contact, a procedural mechanism would be engaged which would be to discharge clients from the participants’ caseloads. This enabled participants to be relatively certain of times when they would have free spaces in their caseloads if clients did not re-initiate contact.
This procedure generally acted to provide a level of client throughput, especially if waiting lists were high.

'It's certainly quite common practice (...) if somebody dna's [does not attend], we'll send them a letter asking them to contact us and then if they haven't within a certain length of time, we will discharge' ('Sally': 12, 376-379).

'We can get thirty odd referrals a week to the team. So the idea, you know if someone doesn't attend, generally people don't get a second offer, they have to get back to us' ('Louise': 115-118).

This strategy may also be considered to be a form of ultimatum, mobilising clients to re-initiate contact, with closure as the outcome if they do not.

2) Sending a Non-Standard Letter. Participants described sending non-standard letters if they had seen clients on previous occasions. Depending on participants' own standards of practice and therapeutic orientation, these correspondences varied and ranged from letters which were only slightly more personalised than the standard letters described above, to letters specifically addressing particular clients' issues and those that presented an interpretation of the non-attendance event. These letters attempted to re-engage clients back into therapeutic work and were often associated with a hope that clients would return.

'After persistent non-attendance, I need to be in a state of mind where I think there's a lot that needs to be addressed here. I can't address it until my client's sitting here, so I will try and do something to induce them to come and be here face to face (...) that may include an interpretation by letter' ('Peter': 4, 101-106).

'If I have actually met the client then it would always be written to them. About specifically what was going on, you know about having seen them and when and what I was thinking and how they were doing. So it would
be much more personalised, once I know somebody' (‘Louise’: 5, 146-151).

‘I was very surprised that he didn’t come back. I wrote a different kind of letter then, which was again quite general. I don’t write very sort of friendly letters I don’t think very often, but it just sort of said something like I was surprised not to see you as you know, so there was some self-disclosure in that’ (‘Jan’: 5, 142-147).

Sending non-standard letters also included sending clients new appointments. With high workloads, these were most usually sent if clients have been seen previously and were known to participants. Sending a further appointment was dependent upon participants’ assumptions that the client wished to return.

‘I would send them another appointment if I decided it was just them being scatty’ (‘Sally’: 12, 387-388).

3) Telephoning Clients. On occasion, participants described telephoning clients after non-attendance. However, two participants described never doing this (Negative Cases - see ‘Peter’: 13, 401-404 and ‘Jan’: 5, 159-166), in particular ‘Jan’ described telephoning clients after non-attendance as an ‘impingement’ (5, 166). She felt strongly that telephone contact should not be initiated and this had become a personal standard for her clinical practice.

For the participants that had initiated telephone contact in the past, it was described as only occurring infrequently and with clients that participants knew well, were concerned about, or where a prior arrangement had been made.

‘You think they need a chance to talk it through before they’ll even bring themselves back here. Then I (...) would phone’ (Louise; 5, 133-135).

Telephone contact was seen as a very direct means which information concerning the non-attendance could be gained.
Sub-Category – Indirect Contact. This strategy involved making contact with other professionals involved in clients’ care. Professionals would be contacted for further information regarding clients, or asked to provide some form of intervention. This strategy was employed to provide information concerning non-attendance that would aid decision-making and further action. Participants described two instances where other professionals would be contacted concerning particular clients after they have failed to attend. The first was when this was part of a departmental procedure and referrers were contacted routinely if clients failed to attend at initial appointments. This acted as a means by which participants could assess clients’ levels of need and whether they wished to attend for further appointments.

‘There would be an automatic letter going to the GP asking whether he or she knows of any circumstances why the individual didn’t attend and so on’ (‘Peter’: 4, 113-116).

The second instance occurred when participants had made an assessment of clients’ levels of risk and it was deemed that clients could commit suicide or harm themselves. Here, contacting other professional acted as a means by which clients could be protected. It acted as a strategy by which responsibility for clients’ well being was held by more than one professional.

‘If they were very distressed and I think there was a risk of potential sort of suicide risk then, other agencies would be contacted anyway’ (‘Kate’: 14, 465-467).

‘[If I had] grounds to believe there was a risk of suicide or self harm or whatever, I would contact the GP or the consultant’ (‘Sally’: 12, 394-395).

Sub-Category – Closure. If participants had not received any contact from clients after letters and deadlines had been sent, clients were discharged from participants’ caseloads. This provided participants with the space available to
offer appointments to clients who were waiting to be seen. How quickly participants decided to close cases depended upon knowledge of the client and their own working practices.

'I'd send a letter and they can get in touch and if they don't then I'll discharge them (...) there would sometimes be a certain amount of oh well, I can go onto the next person on the waiting list {laughs}' ('Sally': 4, 107-111).

Sub-Category – Actions to Reduce Non-Attendance. Participants described employing this strategy as a means of reducing non-attendance rates in the future. It was therefore not directly related to particular clients failing to attend, but was seen as a strategy to try and provide greater certainty that clients would attend for appointments, most usually, initial appointments. Participants described consulting with referring agents concerning appropriate referrals and developing new procedures, such as information packs for prospective clients and opt-in systems. These were viewed as methods by which clients would be more prepared to be seen by clinical psychologists and had made an informed choice.

'Usually when we receive a referral we would then have an opt-in procedure for the client who would need to return the form, even if you return the form blank (...) that's reduce our dna rates for first assessments somewhat' ('Peter': 10, 281-185).

'In discussion with this consultant about how exactly you could word it so that they [clients] you know that they have a bit of choice in that matter [being referred]' ('Kate': 19, 616-618).

As can be seen, this was an active strategy by which participants were able to exert some control and influence over non-attendance rates. However, participants were aware that the success of this strategy would not be complete.
Intermediate Level Category – Considering Use of Session Space

The session space left by the non-attendance event was generally seen by participants as a time that could be usefully utilised and was often associated with a feeling of relief, especially if participants had a high workload. Participants described thinking about what they wanted or needed to do in the extra time available. This included various paperwork and administration tasks and was also associated with the carrying out of client-directed action. The session space also provided a period of time to look after and meet one’s own personal needs. However, there was an awareness that any other activity undertaken in the session space could be easily interruptible if the client arrived late.

'I would probably be aware of all the things I could be doing [whilst waiting for a client] and thinking shall I make that quick phone call? Or won't it be quick?' (‘Jan’: 12, 384-386).

'Or shall I do that quick letter, or a quick bit of looking through the mail' (‘Jan’: 12, 387-388).

As in previous categories, the process of self-supervision led to External Action.

Sub-Category – Management of Workload. If participants had high workloads, they described using the session space to catch up on paperwork and administration tasks. The type of work undertaken was dependent upon participants’ hypotheses about whether clients would attend late or not at all. If participants believed they were likely to have to interrupt these tasks due to the late arrival of clients, they were generally shorter and less time-consuming.

'I might be in the end doing other pieces of work, other pieces of paperwork. But in my mind, if someone still turns up within their time slot, then I would meet with them for the remaining time' (‘Louise’: 12, 346-350).
'With some people I know that they’re on time and if they’re not there after ten minutes, then they are unlikely to come. And I get moved onto something which may absorb me for some time. With other people, I find myself doing bits and pieces that can be left to one side quickly' (‘Peter’: 3, 66-71).

However, although the time made available by non-attendance was generally seen as a useful time to catch up on tasks, one participant described finding this to be less than ideal:

‘I struggle with the sense that I am invited to collude with an attack on therapy (...) And I feel tempted when the session has arrived to make a phone call, write a note, do something which takes up what is their therapy space’ (‘Peter’: 2, 32-36).

Sub-Category – Looking After Self. The available session space was also seen as a time to look after one’s personal needs. This included time to rest, relax, travel to the library or spend time reading. Associated with relief, the session time could be spent recuperating one’s energy levels, especially if participants had a high workload.

‘I can go and put my feet up, have a bit of a rest, or I can read that book I’ve wanted to read, or I can go and get a drink’ (‘Kate’: 11, 369-371).

Summary

Re-organisational strategies employed after non-attendance event were varied and dependent upon many factors. Re-organisational strategies either remained part of an internal process of self-supervision, or participants chose to translate these thoughts into external action. It seems that if non-attendance occurred during the assessment stage of therapy, the re-organisational strategies employed were relatively uncomplicated and often involved pre-designed procedures. However,
if non-attendance occurred during the intervention stage of therapy, participants employed a wider range of re-organisational strategies, based upon their professional judgement, knowledge and experience.
**Main Category – Learning**

The outcome of the non-attendance event, the disruption it caused and the strategies used to re-organise this disruption, acted to provide a learning experience for participants. At one level, non-attendance was so commonplace and relatively uncomplicated, as in the case of the implementation of procedures after non-attendance at initial appointments, that the knowledge and experience gained was minimal. However, if clients failed to attend when therapeutic relationships had been established, there was a more fundamental impact upon participants. How participants sought to re-organise the disruption of these non-attendance events depended much more upon their therapeutic orientation, their judgement and knowledge of clients. Therefore, the capacity for these non-attendance events to become learning experiences was greater.

Through the process of experiencing and dealing with non-attendance events, participants learnt more about the factors that influence attendance, their own working practices and their clients. This may result in the decision to change certain working practices, or to engage in research and audit as a means by which further knowledge of non-attendance events could be gained. Learning about non-attendance events moves back into the category of *Being a Clinical Psychologist* and serves to add to participants’ database of experience.

'I tend to see it [non-attendance] much more as sort of a thing that both happens and is part of the job, but probably is a reflection of something going on in the therapy. And can be usefully used, if and when the client returns. ('Louise': 7, 196-199).

'I’ve been more able to say that I can help some people, but I can’t help others, whereas at the beginning it was I can’t help anybody. And I’m also aware of other reasons why people don’t come for appointments’ ('Carol': 6, 167-170).

As participants became more experienced, their accounts concerning their reactions to non-attendance events seemed to change. There was an increasing
feeling of confidence in oneself and one’s own abilities and a resulting change in participants’ perception and interpretation of the non-attendance events.

'I no longer expect to be some kind of wonderful healer, guru, you know great person who can always say the right things and always offer something to anyone who comes through the door' ('Sally': 6, 186-190).

'I have probably become less narcissistically invested in therapy now. And conversely alongside with that, I take the significance of interruptions and breaks for clients and for therapy a lot more seriously than I used to years ago' ('Peter': 7, 194-198).

In many ways, by experiencing disruption to the regular therapy routine, participants gained a deeper knowledge of the process of therapy and the part they played in this encounter.
DISCUSSION

This section provides a summary and interpretation of the analysis and is presented in light of the existing research literature in this area. A critique of the study is also provided, alongside a discussion concerning issues of reflexivity. This includes the consideration of how the researcher’s assumptions affected the analysis and interpretation of participants’ accounts. Finally, implications for the analysis in terms of clinical psychology as a profession and psychotherapy process research is presented, along with a discussion concerning the transferability of the findings.

The aim of the study was to provide a theoretical account of clinical psychologists’ experiences of client non-attendance. Grounded theory analysis of the interview texts of six qualified clinical psychologists was the means by which the core category and the process model were developed. These will be discussed in turn.

Responsibility as the Core Category

From the analysis, it became apparent that how participants responded to client non-attendance was bound by the overriding notion of responsibility and professionalism. A definition of responsibility is ‘the state or fact of being responsible’ (The Oxford English Dictionary, 1989). The term responsible is defined as ‘morally accountable for one’s actions’; ‘correspondent or answering to something’ and ‘liable to be called to account’ (p. 742).

The term ‘responsibility’ as the core category of the analysis summarised this notion in several ways. It reflected the idea of there being both legal and moral elements in the analysis. As described in the definition of responsibility, being called to account and accountability for one’s actions are also relevant to the analysis.
In terms of legal responsibility, participants were legally obliged to undertake certain duties for their employer, as outlined in their contracts of employment. These included duties associated with accountability, for example the obligation to keep records of client contacts on a regular basis ('Körner Figures'). In terms of non-attendance, legal responsibility meant that participants were obliged to record this as an event. As can be seen by the quotations in the analysis section, having to account for one’s work activity did not rest completely comfortably with the participants. It is suggested that employment obligations to account for how time was spent contributed to the experience of anxiety participants described after clients failed to attend.

Another form of legal responsibility, not explicitly discussed by participants, but of relevance, was the notion of being held to be accountable for one’s actions. This form of responsibility would be applicable to both employment settings and being a practising member of the profession of clinical psychology (the British Psychological Society) and would entail participants adhering to specific codes of practice. The British Psychological Society Code of Practice (1997) notes that members:

‘Taking account of their obligations under the law (...) should hold the interest and welfare of those in receipt of their services to be paramount at all times’ (p. 1).

In terms of therapeutic work with clients, psychologists could be held to account if clients were adversely affected during or after sessions. Disciplinary, civil or legal action could be taken if a complaint was upheld.

Responsibility as the core category also encompassed a moral element. Participants’ accounts reflected a moral responsibility to assist clients in the alleviation of their psychological distress. Non-attendance, particularly of clients who were at an intervention stage in therapy was often attributed by participants in terms of failure. Whether this was accurate or not, this served to provide participants with feelings of self-blame. It is interesting that the experience of self-blame seemed to be more marked for participants who were relatively early on in their careers. Gaining experience of working therapeutically with clients
seemed to be a mechanism by which personal and moral responsibility for clients could be placed into perspective. The accounts of more experienced participants contained an appreciation of clients’ responsibility also.

Responsibility at a personal level was also a theme in the analysis. Participants’ accounts reflected their experience and knowledge in working therapeutically with clients. This conferred an air of expertise and skill, but was also associated with an appreciation of one’s own limitations. Self-responsibility was therefore seen as working to the best of one’s ability, using professional and personal standards as means of guiding practice. This theme is also reflected in the Professional Practice Guidelines of the Division of Clinical Psychology, a subsidiary of the British Psychological Society:

‘In their professional activities, clinical psychologists must ensure that they work to the best of their ability, and adapt their skills and expertise flexibly according to changes in the working context. Clinical psychologists have an obligation to the public and to the profession to maintain and develop their professional competence throughout their working lives and to recognise and work within their limits’


However, feeling responsible for oneself may have served to contribute to a negative affective response to non-attendance, especially if clients failed to attend during the intervention stage. If the non-attendance event was perceived as a failure in one’s own abilities to engage and work with clients, self-blame and anxiety was the result. Although responsibility for oneself holds value, it is a double-edged sword involving personal investment in the outcome. As in the previous section, the accounts of more experienced participants reflected a reduction in how personally important it was for them for a client to remain in therapy.

Participants’ sense of legal and moral responsibility to themselves, their clients and their employers acted to influence how client non-attendance was perceived and acted upon. Legal responsibility obliged participants to follow guidelines in
relation to non-attendance, including types of standard responses. However, the process of accounting one's working activities acted to contribute to experiencing negative affective responses to non-attendance. Feelings of personal and moral responsibility could also produce negative emotional responses if clients failed to attend. The process of gaining clinical experience acted to alter perceptions of moral and personal responsibility. This also led to a change in the impact of non-attendance upon participants.

The Process Model

The process model attempts to account for the self-supervisory process in relation to client non-attendance. The key category in determining how participants self-supervised in relation to this phenomenon was the category of Being a Clinical Psychologist. In many ways this category is similar to the core category of Responsibility and concerns itself with working within systems of employment and the experience and knowledge of participants. However Being a Clinical Psychologist reflects the practical application of these factors in working therapeutically with clients and has a direct influence on the process model. These factors form the basis of participants' identity as psychologists and act as mediators, affecting how non-attendance is construed, experienced and acted upon. However, the factors are not impervious to change and alter as experience is gained and working systems evolve. The description of this category shares similarities with personal construct ideas concerning the image of the person and the construction of events (Kelly, 1955).

The process model asserts that all non-attendance events will produce an affective reaction of some kind. The intensity and type of affective reaction experienced will be dependent upon the factors within the category of Being a Clinical Psychologist and whether clients were at the assessment or intervention stages of therapy. Even if the non-attendance event was anticipated, the client's failure to attend for their appointment produced some form of disruption. At a minimal level, the disruption caused was to create an unoccupied session space that would have to be accounted for in the weekly contact figures. At a greater level, the
disruption caused had a more fundamental impact upon participants and their self-concept.

Research investigating therapists' affective states in therapy has often concentrated on affective reactions in response to impasses within therapy, or termination of therapy. However, it is suggested that some similarities may be drawn with this literature and the present study. A proportion of the non-attendance events described by the participants reflected impasses in therapy, whilst others were indicative of termination. Hill, Nutt-Williams, Heaton, Thompson & Rhodes (1996) investigated therapists' (mostly psychologists) affective reactions to impasses in therapy. Hill et al found that common affective reactions experienced by therapists included frustration, anger and disappointment. Several therapists also described feeling confused and anxious about the impasse and many described having negative thoughts about their own self-efficacy. Hill et al found that the impasse events had lingering effects on the therapists including rumination and self-doubt concerning the impasse. The affective reactions reported in the Hill et al study share many similarities with the experiences of this study's participants, although it is not clear what the longer-term effects are in this particular cohort.

In response to the disruption caused by non-attendance, participants engaged in a variety of internal and action strategies as a means of re-establishing equilibrium. At a basic level, this was to re-establish equilibrium to the organisational system they worked in and included various administration procedures participants were obliged to follow. In terms of disorganisation experienced at more fundamental levels, participants attempted to re-establish equilibrium to their personal systems. This was the case if the non-attendance event had served to act as a catalyst by which participants experienced feelings of anxiety and began to question their abilities and judgement. Many of the strategies described in the process model therefore acted to reduce anxiety, although not exclusively.

The research literature has tended to focus on strategies therapists have employed after termination of therapy, rather than in response to client non-attendance. As previously stated, some comparisons can be made between this literature and the
present study as in some cases, non-attendance was indicative of premature termination. Hughes (1995) prompted by his unease of non-attendance and termination of his own clients engaged in research designed to explore clients’ reasons for non-attendance. This was to investigate ‘what if anything I was ‘doing wrong’ and whether my colleagues had similar experiences’ (p.7). These strategies share elements in common with participants’ descriptions of Attributing Responsibility, Therapeutic Curiosity and Deciding on External Supervision.

However, anxiety reduction was not the sole means of movement within the process model. The desire to seek answers for the non-attendance event and the need to acquire further understanding influenced the re-organisational strategies that were employed. Therapeutic curiosity provided participants with the impetus to consider how the non-attendance event occurred and how they might be able to re-engage clients back into the therapeutic process. This seemed to be a more benign motivating factor within the process model than anxiety reduction. It is suggested that level of clinical experience acted to influence therapeutic curiosity. The accounts of the two most clinically experienced participants contained many instances of wondering about the impact and meaning of the non-attendance event. However, it is also suggested that therapeutic orientation was a relevant factor here, as both of the participants mentioned had partaken in specific psychotherapy training courses.

Several of the re-organisational strategies motivated by therapeutic curiosity have also been found in previous research. Safran, Crocker, McMain & Murray (1990) investigated therapeutic alliance ruptures, of which premature termination was an extreme example. Safran et al’s description of therapeutic alliance rupture markers were similar to those identified by participants as factors considered to be causal of subsequent non-attendance in the Reflection on the Previous Session sub-category. These included overt and indirect communication of negative sentiments by the client, disagreement about goals of therapy, avoidance manoeuvres and non-responsiveness to intervention.

Many of the strategies described by Safran et al (1990) on how therapists attempted to resolve alliance ruptures were similar to those participants described
as engaging in after non-attendance. These included attending to ruptures in the
alliance, awareness of one’s own feelings, accepting responsibility and
empathising with the clients’ experience. This suggests that for some non-
attendance events, participants were seeking to re-engage their clients back into
the therapeutic process. Indeed, the process of contacting clients after non-
attendance as a means of re-engaging them back into therapy has been a strategy
recommended by authors of therapy skills guides (e.g. Dryden, 1988; Gilbert,

Learning was seen as the means by which the process model fed back in to the
category of Being a Clinical Psychologist. The extent that the non-attendance
event was seen as a learning experience depended upon many factors, including
the length of time the client was engaged in therapy, participants’ affective
reactions and the strategies employed to re-organise the disruption of the event.
However, through the mechanism of learning, one outcome of client non-
attendance was that participants gained experience. The desire to learn more
about non-attendance as a therapy event also contributed to movement within the
process model and acted as a motivating factor to increase professional
experience.

The process model attempts to account for non-attendance events at both the
assessment and intervention stages of therapy. It is suggested that the main
categories and many of the intermediate level categories are the same for both of
these stages. However, it is clear from the analysis that there were fundamental
differences in the process model when clients failed to attend during the
assessment and intervention stages of therapy. Affective reactions in relation to
non-attendance during the assessment stage were often less intense and were
frequently experienced as relief, especially if participants had high workloads.
Equally, re-organisation strategies used to re-establish equilibrium were relatively
straightforward, often involving pre-determined departmental procedures.

Conversely, non-attendance during the therapeutic stage of therapy produced a
more complex impact, both in terms of affective reactions and re-organisational
strategies. Affective reactions tended to be more negative, often involving worry
and concern about the client. Re-organisational strategies tended to be more varied, less dependent upon departmental procedures and involved a greater use of clinical judgement to carry them out. Due to the nature of therapeutic interventions, it is probable to assume that participants were more invested in the process and outcome of therapy than they would be if they had only seen a client on one occasion, or not at all. Depending upon clinical experience, therapeutic orientation and other personal experience factors there would be different levels of personal investment in the therapy. This may have acted as a contributory factor to the feelings of failure and self-blame some participants described after the non-attendance of a longer-term client.

**Negative Affective Reactions to Non-attendance**

It is interesting to ask why participants frequently described experiencing a negative affective reaction in relation to client non-attendance. Negative affective reactions such as anxiety, worry, and self-blame were described as responses often elicited by clients failing to attend during the intervention stage of therapy. However, some participants also described experiencing anxiety and self-blame in relation to non-attendance during the assessment stage of therapy. It may be the case that some of these reactions were functional, for example in response to the non-attendance of an actively suicidal client. However, this does not seem to account for every negative affective reaction. As has been discussed, a proportion of the re-organisational strategies described were aimed at anxiety-reduction. Therefore, several points are considered as to why anxiety may have been experienced in the first place.

*The Concept of 'Super-Therapist'*

'No one quite likes to think that they might not be a super therapist' 
*(Jan*: 14, 465-466).
This quotation reflects one idea as to why anxiety and self-blame was experienced by participants after client non-attendance. In general terms, non-attendance may be perceived by therapists in terms of failure. This may be especially the case if they have a view of their ideal selves as 'super-therapists'; namely as therapists who have the ability to help every client they see. It is not difficult to see how the concept of one’s ideal self as a ‘super-therapist’ could develop. Walsh (1990) discussed some of the reasons why people wanted to train as therapists. Included were factors such as the reinforcement of one’s self-image as a caring person, denial of one’s neuroses and personal needs and fantasies of omnipotence. Even once a therapist has received training, fantasies of ‘rescuing’ the client and over-protective countertransference have been described as regularly occurring phenomena (Hoyt, 1985; Watkins, 1988).

Martin & Schurtman (1985) described anxiety as a common response to termination of therapy. Some of the reasons speculated upon as to why this occurred, included the literal loss of a meaningful and rewarding relationship and the perceived loss of therapists’ professional role, as the therapist was no longer seen as the ‘helper’. As Walsh (1990) suggests, there is a tendency for therapists to experience their sense of self-esteem in terms of professional accomplishments. If a rewarding and reinforcing relationship is lost in which therapists’ professional role was clearly defined it is not surprising that anxiety and disappointment are the result. This is reflected in a study by Duryee, Brymer & Gold (1996) who discussed how anxiety was a common experience for neophyte psychotherapy trainees. They suggested that trainees’ self-esteem was rooted in outstanding performance and feelings of ineptness were often the result of being relatively clinically inexperienced.

This suggests that clinical experience may be an important factor in how termination and non-attendance is perceived. There is research evidence to suggest that clients of less experienced therapists are more likely to terminate therapy prematurely than of more experienced therapists (Bergin & Garfield, 1994). If, as has been suggested, less experienced therapists may be more performance and success driven than their more experienced counterparts (Duryee
et al., 1996) and if perceptions of self-esteem rested on successful performance, then anxiety may be seen as an obvious reaction.

From looking at the accounts of the two most newly qualified participants (‘Kate’ and ‘Carol’) it suggests that clinical experience may be an influencing factor in negative affective responses to non-attendance. ‘Kate’s’ account seems to take a defensive stance in which she describes her attempts to engage clients in therapy and to provide her clients with opportunities to express their concerns and to opt-out if they wish. Namely, ‘Kate’ talks about what she is doing right. She only very briefly touches upon feelings of self-blame and anxiety as affective reactions to non-attendance. It is possible that ‘Kate’s’ account acts to defend herself against the experience of anxiety and negative affect.

Alternatively, ‘Carol’s’ account contains a great deal of anxiety. ‘Carol’ describes feeling responsible for nearly all non-attendance events, including those where she hasn’t even met the client. This may reflect a high level of personal responsibility for the failure of clients to attend. It is not known how ‘Kate’ and ‘Carol’ viewed themselves as therapists, but it is interesting to reflect upon their accounts.

The notion of ‘super-therapist’ may also be a legacy of the clinical psychology training process. Moorey & Markman (1998) identify the tendency for clinical psychology training courses to produce technicians reliant on technical procedures, rather than therapists. This may serve to engender a belief that the ability to utilise these technologies guarantees success. When the technician is faced with the reality of clinical practice, anxiety is the inevitable result as they discover that clients do not respond to the textbook procedures. Ironically, research suggests that it is the quality of the therapeutic relationship that elicits change, rather than the use of particular techniques (Orlinsky & Howard, 1986; Safran et al., 1990).

Moorey & Markman suggest that instead of anxiety being associated by clinical psychologists with inadequacy or incompetence, the experience of anxiety in fact, reflects an accurate appraisal of the complexity of interpersonal and social
realities. The notion of 'super-therapist' is a myth, created and engendered by personal factors and reinforced by training but which stifles therapeutic curiosity in response to non-attendance with feelings of anxiety, disappointment and self-blame.

_Clinical Psychologists as 'All-knowing Experts'._

Closely related to the notion of 'super-therapist', but in a wider context is the view of clinical psychologists as all-knowing experts. As will be discussed, organisational and societal factors engender and reinforce this concept. It is therefore suggested that participants' negative affective reactions to non-attendance were influenced by the discrepancy between the expectations of themselves as experts and the realities of clinical practice. As already mentioned, clinical psychology training may start to engender this notion by the emphasis on the learning of techniques (Moorey & Markman, 1998). Emphasis on 'scientist-practitioner' models within clinical psychology may serve to deepen this view of the omniscient scientist applying their technical expertise (Pilgrim & Treacher, 1992). However, the notion of expert is not peculiar to clinical psychology. Mair (1992) discussed how psychotherapy training in general engenders this view and how the 'rhetoric of the pseudo scientist' reinforces this image.

The identity of clinical psychologists as all-knowing experts continues to be fuelled within the profession. Jones (1998) charts the progress of this view within the National Health Service over a period of several years. He discusses how the Manpower Advisory Service Report (MAS Report, 1989), which reviewed clinical psychology as a profession served to enhance clinical psychologists' identity as all-knowing professionals. Jones describes how these 'extravagant claims' presented in the MAS Report prompted the profession to move into the consultancy model of service provision. As consultants, clinical psychologists impart their knowledge and skills to other professions, further promoting an identity as expert. The awarding of doctoral status degrees by training courses in recent years has also promoted this view (Jones, 1998). However, this has been described as a 'fraudulent identity' (Mollon, 1989; Jones, 1998) of which the reality and complexity of clinical practice serves to act as a reminder.
The reasons why clinical psychologists and other therapists have been promoted as all-knowing are complex and may be engendered by less than altruistic motives. The notion of expertise in psychology may be viewed as a reinforcement of a mythology that places responsibility for distress within the patient and the responsibility for the 'cure' within the expertise of the therapist (Moorey & Markman, 1998). This may be further enhanced by the 'mystification' of therapeutic skills and knowledge. This creates a power differential between therapist and client in which the therapist has influence and control (Pilgrim & Treacher, 1992). Increasing the gradient to this power differential is that most ordinary people trust experts (Mair, 1992). The reinforcement of the notion of therapist as an all-knowing expert serves to maintain this power differential, fostering clients' dependency on the therapist (Searle, 1993).

This raises wider issues concerning the role of the therapist within society and sociological theories have attempted to address some of these issues. In Pilgrim & Treacher's (1992) analysis of clinical psychology as a profession, sociological theory in relation to clinical psychology was discussed. For example, Neo-Weberian theories highlight the consequences of the bureaucratisation of health care after the development of the National Health Service in 1948. Therapists lost their autonomous status by moving from private practice to National Health Service practice and the state rather than individual clients became therapists' employers. The promotion of expertise has therefore become an attempt to claim a role within a state service, rather than what may be in the best interest of clients. This relates to the notion of responsibility and accountability discussed earlier. As Øvretveit (1993) suggests 'employed psychologists are accountable for meeting and fulfilling their employers contracts, and this can conflict with their accountability to individual clients' (p. 30).

The consequences of professionals being employed by a state service have also been hypothesised from a neo-Marxian perspective (Pilgrim & Treacher, 1992). According to Pilgrim & Treacher's account, social regulation and control are the agendas of the state and state services. Professionals involved within state services are by association, in collusion with this view. The individualisation of
psychological problems serves to divert attention from the social determinants of distress. The promotion of therapists as all-knowing and the individualisation of distress reinforce power differentials and serve to maintain clients in a disadvantaged position. This reflects a paternalistic approach to client care whereby the therapist ‘knows best’ for the client and behaves towards them in accordance with these beliefs (Searle, 1993).

Alternatively, however, the promotion of clinical psychologists as all-knowing experts may be seen as a way in which therapists can defend themselves from the real anxiety of working with distressed individuals. Expertise acts to create a protective distance from the client (Moorey & Markman, 1998). A reliance on the application of techniques towards clients is also a means by which this defence is displayed (Mollon, 1989). Similarly, the mystification of therapy and the view of the therapist as all-knowing may engender the view of therapy as containing magical properties and may appeal to people looking for meaning in their lives (Smail, 1987). However, the mystification of therapy may serve to relieve feelings of helplessness in both clients and therapists alike (Mair, 1992).

From the present study’s findings, it may be seen that the conflict of responsibilities towards the employer and the client, and defending oneself against anxiety seem applicable. There is also a suggestion that there is an expectation on the behalf of clients for therapists to have high levels of expertise. Tinsley, Bowman & Westcot Barich (1993) reported that counselling psychologists complained of unrealistically high expectations in their clients for them to impart expertise. Of a similar nature, but within a medical context, Furnham & Smith (1988) found that patients visiting general practitioners tended to agree with the statement that ‘doctors can almost always help their patients feel better’. It seems that faith in professionals is not exclusive to clinical psychology. However, as previous research has shown, premature termination is a frequent outcome when clients’ expectations are not realised (Tinsley et al, 1993; Bergin & Garfield, 1994).

In hypothesising about the reasons why participants experienced negative reactions after client non-attendance, it is not difficult to see that participants may
have been caught up in the professional culture that portrays clinical psychologists as all-knowing. The identities of the participants may have been based upon the view that they should espouse this identity. The negative affect experienced after client non-attendance may be the inevitable result of the realisation that the image of themselves as experts does not match the inherent complexity of clinical practice. Indeed, in reading participants’ accounts, there seemed to be a developmental process by which, in the light of the realities of clinical experience, participants were re-appraising their limitations and abilities.

Organisational Pressure.

In terms of the structure and working of the NHS, clinical psychologists are tacitly and explicitly expected to embrace a rapid-throughput model, especially in light of long waiting lists (Jones, 1998). This has been termed by Jones as ‘the sausage-machine approach to health and mental health’ (p.5). The development of the ‘two-plus-one’ model of therapy has served to reinforce this view (Barkham & Shapiro, 1989). However, the costs of the rapid-throughput approach can be seen in terms of both clinical psychologists and their clients. Walsh (1990) stated:

‘As NHS employees are being put under intolerable pressure to organize the provision of client care around targets of efficiency and economy, self-care strategies may have little place in the current requirements for larger caseloads’

Equally, clients may experience difficulties with this approach. Seager & Jacobson (1993) criticise the ‘two-plus-one models’ of therapy, seeing them as a means of saving resources, rather than enhancing client benefit. Jones (1998) reports that if clinical psychologists are to be therapists rather than ‘safety valves’ they should see clients for a minimum of three sessions, with the aim of helping clients learn more about their psychological functioning and how to change it to their advantage.

The negative affective responses described by participants may therefore be related to organisation pressures to increase caseloads and reduce lengthy waiting
lists. Indeed, ‘Carol’s’ account describes her anxiety that she does not seem to be busy enough if several clients fail to attend in a short time period. ‘Jan’ on the other hand describes feeling angry towards clients that they have failed to fill a session slot many other people on the waiting list would be needy for. The accounts do seem to reflect a feeling of time pressure and an expectation for participants to discharge clients quickly after non-attendance (especially at initial appointments) and a rapid move to offer an appointment to the next person on the waiting list. However, Guinan (1995) has suggested that the use of procedures such as these to work through waiting lists need to be weighed against client focused care and clinical psychologists need to consider ‘whose side are we on?’ (p.3).

The Role of the Re-Organisational Strategies

The experience of anxiety and negative affect seemed to be a commonly experienced reaction to client non-attendance. As discussed in the previous section, there have been several suggestions as to why this might be the case. The following section discusses the roles of the re-organisational strategies as responses to the experience of negative affect.

Re-Organisational Strategies as Means of Repairing Breaches

Some of the re-organisational strategies employed by participants after client non-attendance during the intervention stage of therapy were designed to encourage the client to return to therapy. That is, participants’ perceived the non-attendance event to be indicative of a breach in the therapeutic alliance. These strategies included sending personalised letters, telephone contacts and the involvement of other professionals to contact clients. As previous research has suggested, therapists are often unaware of clients’ negativity and dissatisfaction with therapy (Rhodes, Hill, Thompson and Elliott, 1994). This may be because power differentials in the therapeutic relationship make it difficult for clients to challenge therapists directly and so clients may do this in more subtle ways (Rennie 1994). Anger and other negative feelings are often those which are less
likely to be communicated directly by clients (Safran, 1993). Non-attendance may then be an indirect means by which these feelings are communicated to therapists. This suggests that non-attendance may have become a trigger event by which participants realised that an alliance breach had occurred.

Kohut (1984) suggested that breaches in the therapeutic alliance are often the result of empathic failures on the part of the therapist, with major empathic breaches often leading to premature termination. In the resolution of empathic breaches, several researchers have suggested that it is important that the therapist accepts his or her responsibility for the difficulties in the therapeutic relationship (Safran et al, 1990; Agnew et al, 1994; Rhodes et al, 1994). The categories of Therapeutic Curiosity and Attributing Responsibility may have been the means by which the participants in the present study speculated about and accepted their part in breach events identified in previous sessions. Negative affective reactions in response to clients' non-attendance provided participants with the impetus to employ re-engagement strategies designed to repair the alliance breach. However, as was described in participants' accounts, these strategies were not always successful. As Hill et al (1996) suggest, therapists' negative feelings often lingered when clients did not re-engage in therapy.

Re-Organisational Strategies as Defence Mechanisms

Within psychoanalytic and psychodynamic conceptualisations of distress, defence mechanisms are described as ‘unconscious cognitive strategies for keeping disturbing, emotionally charged ideas at a distance from consciousness’ (D. L. Smith, 1990). Several types of defence mechanisms have been described including repression, denial, projection and displacement (see Brown & Pedder, 1991 for definitions). Martin & Schurtman (1985) have suggested that in response to termination, therapists' defences come into play as anxiety over the termination event rises to uncomfortable levels. In a study by Boyer & Hoffman (1993) the authors found that counsellors' history of loss was predictive of levels of anxiety and depression experienced during termination phases of therapy. Similarly, Hill et al (1996) suggested that therapists' personal issues were
involved in impasses during therapy that subsequently led to premature termination. It is possible that the participants in this study were experiencing personal history factors that may have contributed to their feelings of anxiety to the non-attendance event. If so, they may have unconsciously defended themselves to prevent the anxiety reaching unbearable levels.

Martin & Schurtman (1985) utilised The Defence Mechanism Inventory (Gleser & Ihilevich, 1969) to describe the types of defence mechanisms used by therapists in response to termination. In looking at these defences, there are some similarities to the re-organisational strategies described by the participants in the present study. For example, Martin & Schurtman describe ‘reversal of affect’ in their categorisation. This involves responding positively to a frustrating object when one is really experiencing negative feelings. It is possible that some of the client-directed actions designed to re-engage clients back into therapy were positive responses defending against participants’ frustrations towards the clients’ non-attendance. Another defence mechanism described in the categorisation was ‘turning against the self’. Here, in defending oneself against the increase of anxiety, aggression is directed inwardly. This is achieved through self-depreciation, self-abasement or depression. Participants’ expressions of self-blame in response to non-attendance and acceptance of responsibility may have been suggestive of this particular defence.

In Martin & Schurtman’s review, supervision (internal and external) was seen as an important means by which anxiety associated with termination could be dealt with. All the participants described engaging in supervision activities as a means of gaining further understanding of therapy issues. Although it is not known in this study whether participants had significant loss histories that may have been impacting upon their reaction to non-attendance, it is possible that participants defended themselves against the anxiety of the impending termination of clients.

Defending oneself against the anxiety of client non-attendance finds parallels with the studies of Isabel Menzies Lyth (formerly Isabel Menzies). In 1961, she conducted interviews at a London hospital, investigating levels of anxiety within nursing staff. The author concluded that being a nurse per se did not fully account
for the levels of anxiety nurses were complaining of. Instead, the development of ‘socially structured defence mechanisms’ within the organisation provided methods for the alleviation of anxiety. However, these mechanisms were seen as functioning inadequately, acting to facilitate the evasion of anxiety, but contributing little to its true reduction.

Some of the re-organisational strategies described in the present study share similarities with Menzies’ (1961) findings concerning the standardisation of procedures and the ritualisation of task-performance. The adherence to standard procedures and having to complete administrative paperwork as a response to client non-attendance may be seen as the organisation’s attempts to evade anxiety inherent in the client work of clinical psychologists. However, as the accounts describe, participants found these procedures as contributing to workload and increased feelings of time pressure. This is similar to the paradoxical effect described in Menzies’ study of organisational methods aimed at reducing anxiety, in fact increasing it.

**Summary**

Being legally and morally responsible to one’s employer, one’s clients and oneself was the overarching theme within the analysis. This theme’s influence was identifiable throughout participants’ accounts of how they reacted and self-supervised after clients’ failure to attend for scheduled appointments. This process was also influenced by participants’ identities as clinical psychologists working within the National Health Service and their clinical and training experiences. Reactions to client non-attendance were varied, although many of the accounts described a negative affective response. Equally, many of the re-organisational strategies implemented after non-attendance events were aimed at anxiety reduction. It was suggested that clinical training and clinical psychology as a profession espoused a culture of all-knowing expertise. The reality gaps between participants’ self-view and the pressures and complexities of clinical practice served to produce negative affective reactions as responses to non-attendance. The gaining of clinical experience acted as a mechanism by which
participants' self-view could be balanced against the realities of practice. However, client non-attendance also prompted a response of curiosity from participants and several of the re-organisational strategies described also acted as means to re-engage clients into therapeutic work.
Critical Reflection on the Study

Recruitment of participants. Due to pragmatic and time considerations, recruitment of participants for the study was not based on standardised procedures. Some of the participants were acquaintances of the researcher, whilst other participants were recruited through colleagues. This of course, raises issues concerning the nature of these research relationships. Grafanaki (1996) discussed similar issues from her experiences of involving friends and acquaintances as participants in her qualitative research study. Some of these issues involve how dual roles and role boundaries can create tensions in the process of interviewing participants and can influence how the researcher interacts with participants.

It is hoped that the researcher’s acquaintance with participants helped to promote a relaxed and collaborative relationship in the interview setting, where they felt able to be as open as possible. From the interviews it can be seen that participants expressed issues which may have been uncomfortable to them. However, it is recognised that participants may have been at times, reluctant to disclose certain aspects of their experience due to the nature of the research and the researcher’s connections with certain institutions.

In terms of considering more standardised methods in the selection of participants, recruitment may have been achieved through region-wide advertising. This may have involved visiting staff meetings within psychology departments, or placing a request for volunteers in publications sent to all psychologists within the local area (e.g. ‘Training Link’). From responses of interest, the researcher could have then selected participants in a more standardised fashion. As part of the interview inquires on participants’ use of particular departmental procedures in response to non-attendance, selecting participants from different departments may have provided a more varied response than the ones received in this study.

It is a well-recognised phenomenon that people who volunteer to be involved in research studies may not be representative of ‘normal’ populations (Parker, 1994). This notion is also relevant for the recruitment of volunteers for qualitative studies. In the present study, due to the nature of the recruitment process,
participants were eager to be involved in the study and declared interest in the topic of investigation. It is certainly possible that as participants were willing to talk about their experiences of client non-attendance in detail, they were a fairly self-reflexive group at the outset. Indeed, the two participants who had the most years of clinical experience had undergone further training in a therapeutic orientation that generally encouraged self-reflexivity through personal therapy and regular supervision. As the previous paragraph suggests, recruitment of participants may have been achieved in a more systematic fashion. However, through consenting to be involved in a study of this nature requiring the discussion of one’s experiences, this suggests that a certain level of interest and self-analysis may already be present.

Number of Participants. Rennie et al (1988) have suggested that saturation of categories generally occurs after the analysis of five to ten protocols. As can be seen, this study’s conclusions are based on the analysis of six interview texts. Although this has been suggested to be an adequate number of participants for this type of study (Turpin et al, 1997), it is clear from the analysis that saturation of some of the sub-categories was not complete and based on only a few participants’ descriptions.

An example is given in the development of the sub-category termed Informal Supervision. Only ‘Carol’ mentioned using this form of supervision and it was therefore presented as a possible sub-category on a preliminary basis. Interviewing more participants may have revealed that this category was relevant within the Process Model. Equally, the further questioning of the participants within the study may have supported the development of this sub-category. In this case, theoretical sampling was not employed early enough in the analysis and participants could not be re-interviewed.

Theoretical Sampling. As noted previously, pragmatic and time considerations meant that participants were not recruited for the study using the method of theoretical sampling. Similarly, participants were not re-interviewed during the process of data analysis. Although negative cases were analysed in light of the emerging theory, the lack of theoretical sampling in these other areas does have
implications in terms of the developed theory. As theoretical sampling helps to fill out categories and to discover variation within and between them (Charmaz, 1995), the developed theory may therefore not be as rich, dense or conceptually grounded than if theoretical sampling had been carried out (Henwood & Pidgeon, 1992; Pidgeon, 1996). This is particularly relevant in reference to the implementation of departmental procedures as a response to non-attendance. Three of the participants worked within the same departmental specialty and it is likely that if theoretical sampling had been conducted, this area within the developed theory would have had greater density and richness.

**Issues of Reflexivity.** As already discussed elsewhere, reflexivity emphasises an awareness of the researcher’s own presence in the research project (Smith, 1996). In an attempt to acknowledge some of these issues, the researcher kept a field journal in which thoughts and interpretations were noted. It is accepted however, that identifying a researcher’s implicit assumptions is a difficult task (Rennie et al, 1988). In terms of this study, the researcher was in the final stage of qualification as a clinical psychologist and throughout training, clinical workload had been closely evaluated. Therefore, the researcher’s experience of client non-attendance at this time may have been coloured by the training process.

Another consideration is that due to the training process, it was at times difficult not to refrain from interpreting participants’ experiences as what might have been expected if the researcher was in a therapeutic setting. The researcher’s relative unfamiliarity with non-therapy interview methods may have also made this more difficult. However, it is hoped that a stance of ‘empathic neutrality’ (Patton, 1990) was maintained and that participants’ responses were not forced. By being responsible for transcribing the interviews enabled the researcher to gain some insight into how questions were phrased and her role in the interaction. These observations and reflections were noted in her field diary and discussed with other members of the qualitative group.

In looking at the analysis in light of issues of reflexivity, it is interesting that the experience of negative affect was described as a frequent reaction to non-attendance. It is certainly possible that this accurately reflected participants’
accounts of non-attendance events. However, it may also be possible that the interpretations reflect the researcher's experience of the training process. Participant feedback on an initial conceptualisation of the process model was helpful in enabling re-evaluation of the interpretations made. This was especially useful in terms of the participants who had many years of clinical experience and for them, therapeutic curiosity was seen as a common response to non-attendance. The interpretation of the process model was therefore amended to take account of the relevant importance of this category. An alternative interpretation of the study therefore, might be that therapeutic curiosity, rather than negative affect was the greatest motivator in the process model.

Respondent validation has been criticised in terms of its usefulness within the research process (e.g. Smith, 1996) and it is accepted by the researcher that this method is not problem-free. However, as the participants in this study had an understanding and knowledge of research processes within psychology, it was felt that their contribution to the interpretation of the analysis would be valuable. Participants provided a critical appraisal of the researcher's interpretation of the analysis and prompted the researcher to re-evaluate conclusions reached. Indeed, some revisions of the interpretation of the analysis were made based on participants' comments. Negative case analysis also aided the author in considering alternative interpretations of the interview texts. As can be seen in the analysis section, negative cases and comments provided by participants are included as a means of illuminating nuances in the process model.

**Implications for Clinical Psychology**

The implications of this study in relation to clinical psychology pays attention to the significance of non-attendance events and how these are perceived and acted upon. As negative affect seems to be a recurrent aspect in participants' accounts, implications in terms of reducing anxiety and other negative affective reactions are discussed. These are presented both in terms of implications for the training of clinical psychologists and clinical psychology as a profession.
Training. As mentioned previously, there is evidence to suggest that the quality of the therapeutic alliance is the best predictor of outcome (Safran et al, 1990). However, clinical psychology training tends to focus on teaching a wide variety of technical procedures in order to provide an eclectic conceptualisation of therapy and psychological distress (Moorey & Markman, 1998). As Pilgrim & Treacher (1992) suggest, the personhood of the trainee is often lost in the training process and trainees often emerge from training with a feeling of technical information overload. Perhaps more concentration needs to be on first developing the person within training as someone who is capable of building effective therapeutic alliances, rather than as a technician. Considerations of theoretical orientation and technical skill can become a training focus once the former has been established. The anxiety participants experienced after non-attendance may be reflective of the reality gap between technical skill and the complexity of the dual nature of therapy. Increased confidence and an awareness of the importance of the establishment of a therapeutic alliance may go some way to reduce this gap.

From the analysis, it was clear that some non-attendance events were perceived by participants to be indicative of a breach in the therapeutic alliance. Bordin (1979) has suggested that breaches in the therapeutic alliance and misunderstanding events are an inevitable feature in therapy. If this is the case, the ability to identify and intervene at an early point in the developing breach may prevent clients taking more drastic means to communicate their dissatisfaction, such as through non-attendance and premature termination. The training of therapists to accurately identify and acknowledge developing breaches has been suggested in the literature (Safran et al, 1993; Rhodes et al, 1994; Hill et al, 1996). The resolution of breaches and misunderstanding events can lead to therapist growth and learning (Rhodes et al, 1994). The category of Learning within the process model supports this suggestion, although participants experienced a fair degree of negative affect to reach this point. The training of therapists to identify and to resolve therapeutic breaches may reduce the levels of self-blame and anxiety in response to the non-attendance of dissatisfied clients.

Within clinical psychology, therapeutic failure seems to be rarely discussed, let alone published (Harper & Spellman, 1996), although all therapists experience
failure of an intervention at some point (Davison, 1995). The reasons for this are manifold. Harper & Spellman (1996) have made several suggestions why clinical psychologists are reluctant to discuss failure. This includes, discomfort in facing failure, clinical psychologists needing to project themselves as super-competent and the dominance of the discourse of success in professional culture (e.g. positive outcome bias of research publications). However, Strupp et al (1992) suggest that in fact, analysis of poor outcomes in therapy can provide a wealth of information, as their examination of a case of premature termination demonstrates. The authors suggested that the intensive comparison of best-worst outcomes for the same therapist could provide more useful information than group comparisons of outcome. Perhaps then, it is time to place less emphasis on the exaggeration of competency and make space for the discussion of failure. For example within training, critical analysis of negative outcome case material may not only enhance learning, but may also serve to promote a balanced appraisal of trainees' abilities and limitations.

The Profession. Pilgrim & Treacher (1992) argue that self-reflexivity is generally not strongly valued by clinical psychology as a profession. However, as has been discussed in previous sections, therapists' personal histories affect therapeutic processes (e.g. Boyer & Hoffman, 1993). It is certainly possible that participants' histories may have contributed to clients' failure to attend. However, if clinical psychologists within particular therapeutic orientations and the profession itself do not seem to see self-reflexivity as a priority, then therapists' personal contributing factors to misalliances may be overlooked. Perhaps greater emphasis needs to be placed on the importance of clinical psychologists being aware of their contribution to the therapeutic alliance. This may involve the encouragement for qualified clinical psychologists to seek regular supervision, or even personal therapy if issues are difficult to manage. The promotion of self-reflexivity can be developed during training by the encouragement of trainees to critically appraise their contribution to therapy sessions. This includes the emphasis that this process continues throughout practice.
As clinical psychologists have further sought to gain the mantle of all-knowing expert, mystification of therapy has often been the result (Moorey & Markman, 1998). As already discussed, anxiety in response to non-attendance may reflect the reality gap between expert and practical application. Anxiety on behalf of therapists and clients alike may be reduced if mystification of therapy is actively combated. This would involve open acceptance and discussion of clinical psychology’s limitations as well as its abilities, seeking a greater balance between seeing what is best for clinical psychology in the National Health Service, to see what is best for clients (Jones, 1998). Promoting the view of all-knowing expert may serve to impress clients, but it may also serve to intimidate some into never attending. It creates a distance from those to whom clinical psychologists should be committed (Newnes, 1996). Ethically, clinical psychology as a profession needs to ask itself ‘who is the client?’ (Lindsay & Powell, 1994).

Implications for Psychotherapy Process Research

As mentioned in the Introduction section, at the end of the 1980s there began to be an increasing crisis of confidence concerning the methods employed in psychotherapy process research. Up to that point, large-scale quantitative studies had been able to demonstrate that psychotherapies were effective, although the specification of the subtle mechanisms of change had proved a more elusive task (Stiles, Shapiro & Elliott, 1986). Psychotherapy process research to that date had tended to employ quantitative research designs such as treatment group comparisons, clinical trials and placebo controls (Butler & Strupp, 1986). However, the outcomes of these types of research tended to have little impact on the specific clinical work of practitioners (Butler & Strupp, 1968). It seemed that research of this nature was not applicable to the day to day work of therapists.

Arising from this discontent, calls were made for a shift in research paradigm. This was not only in terms of the phenomena to be researched, but also the methods by which this may be achieved. Interest was expressed in the investigation of the therapeutic alliance between client and therapist. The research of processes within therapy were also seen as areas of investigation and a
means by which research results could be made more applicable to clinicians (Scott Richards & Lonborg, 1996). The use of qualitative methodologies were advocated as a particularly suitable means by which psychotherapy process research could be moved forward and freed from its period of stagnation (Rennie et al., 1988; Rennie, 1992; McLeod, 1996; Smith, 1996b).

The present study has attempted to describe the processes involved in how clinical psychologists’ react and self-supervise after client non-attendance. The detail provided in the analysis is based on the personal experiences of clinicians themselves, and the categories have not been pre-defined by the researcher, as may have been the case if a questionnaire had been developed. In terms of the applicability of this study to the field of psychotherapy process research, it has provided a new perspective on a phenomenon that is all too common in the working lives of clinicians, but yet is neglected in the research literature.

It is possible that some aspects of the analysis can be empirically tested, such as the hypothesis that all non-attendance events produce an affective reaction of some kind. This may be the starting point of developing a measure of this phenomenon. Equally, the continued use of qualitative methods in this area may be able to further elucidate the individual experiences of clinicians and the subtleties of these processes. As a contribution to the area, this study has reinforced the viability of qualitative methods as a means of investigation, and has shed light on a clinically important topic.

Suggestions for Further Research

In terms of using qualitative methods to investigate how therapists’ self-supervise in relation to non-attendance, it may be interesting to interview different mental health professionals working with the National Health Service. This may include psychotherapists, community psychiatric nurses and psychiatrists. The effects of differences in organisational responsibility upon these professionals and their different processes of training may be able to demonstrate whether the Process Model is robust and transferable. It may also be of interest to interview therapists
working in private practice, especially in terms of where the therapists feel their responsibilities lie. This is in relation to private practice therapists receiving their income from clients, rather than an organisation.

In terms of issues raised from this analysis, further research may investigate how therapists' personal issues influence their perception of non-attendance. This is reflected by this study's conclusions that some of the re-organisational strategies employed by the participants acted as defences against anxiety. Previous research also suggests that therapists' personal issues can contribute to breaches in the therapeutic alliance (e.g. Hill et al, 1996). Issues such as self-esteem and perceived self-efficacy may also be of relevance here.

The current study also commented on the role of participants' experience and how this influenced their perception of non-attendance. The mechanism of learning was indicated in the Process Model as an outcome of a non-attendance event that resulted in an increase in participants' experience. Therefore, it would be of interest to investigate how therapists' perceptions of non-attendance change as clinical experience is gained. There was evidence in the interview texts to suggest that participants became less anxious over time. Further research, perhaps of a longitudinal design, may be able to elaborate upon this.

**Conclusions**

The present study suggests that clinical psychologists' own legal and moral responsibilities are pervading factors in how client non-attendance is perceived and acted upon. A level of tension seems to exist between the responsibilities towards clients and those towards the employing organisation. Whilst clinicians seem to be expected to work at the pace by which referrals are sent, clinicians' responsibilities to their clients may be in opposition to a rapid through-put model. Non-attendance as an observable and accountable event is a point at which these tensions become apparent and visible.
In terms of how clinical psychologists react and self-supervise in relation to client non-attendance, several mediating factors influence this process. However, clinicians frequently experienced a negative affective reaction in response to the non-attendance event. This seems to be greater than the expression of therapeutic curiosity that may be considered to be a more therapeutically relevant response. As mentioned previously, the experience of negative affect may be reflective of an incongruity between organisational and clinical responsibilities. It may also be reflective of a general espousal by clinical psychology as a profession to promote an expert identity. The ‘reality gap’ between the expert identity and clinical practice, especially in less experienced clinicians, promotes anxiety about one’s clinical abilities and level of competence.

The present study suggests that clinical psychologists engage in several strategies after the non-attendance event. Some of these are aimed at anxiety-reduction and may be construed as being of a similar nature to defence mechanisms, described in the psychoanalytic literature. However some of the strategies are also employed as a means of re-engaging clients into the therapeutic process. Their failure to attend may be indicative of a therapeutic alliance breach, which the clinician has been prompted to attempt to repair. A process of learning takes place by which the clinician gains experience in the handling and identification of therapeutic alliance breaches. Non-attendance therefore also acts as a point by which part of the complex structure of the therapeutic alliance becomes visible and open to investigation. This shares similarities with Garfinkel’s (1963) advocacy of the investigation of disorganised interaction as a means of illuminating how social structures are ordinarily maintained.

For clinical psychology as a profession, the present study has several implications. Practically, training courses can aim to promote the early identification and management of therapeutic alliance breaches. A non-attendance event may be seen as clients’ active expression of dissatisfaction with the therapeutic relationship. This may have been able to be prevented if therapists intervened at an earlier stage. Training courses can also place more emphasis upon training in building and maintaining high-quality therapeutic alliances. The current emphasis on the training of therapeutic techniques may serve to reinforce the notion of the
clinical psychologists' identity as all-knowing experts and increase the feeling of incompetence when clients' terminate prematurely from therapy.

Within a wider context, clinical psychology as a profession needs to encourage a more self-reflexive approach to clinical practice. The general espousal of clinical psychologists as all-knowing may be incongruent to the acceptance of one's abilities and also one's limitations. The analysis of negative outcome case studies within the published literature may be one means by which self-reflexivity can be encouraged. This may act as a refreshing challenge to some clinicians' honestly expressed concerns that they are the only ones to experience therapeutic failure. Perhaps, by the profession's promotion of clinical psychologists as all-knowing, it is reinforcing some of the organisational pressures placed upon itself. As the study suggested, client non-attendance serves to highlight the effects of these pressures. Some discontented clinicians within the profession have called for clinical psychology to re-carve its identity as a profession with expertise, but not omnipotence. The present study suggests that this call is a valid one.
References


Balfour, A. (1986) An innovation to encourage more 'dropping in' to GP referrals (and less dropping out!). *Clinical Psychology Forum, 5*, 14-17.


Turpin, G.; Barley, V.; Beail, N.; Scaife, J.; Slade, P.; Smith, J.A. & Walsh, S. (1997) Standards for research projects and theses involving qualitative methods:


APPENDICES
Appendix 1

11 November, 1997

Ms Alison Tweed
Trainee Clinical Psychologist
Centre for Applied Psychology
University of Leicester
Leicester LE1 7RH

Dear Ms Tweed

Reactions of Therapists to Therapeutic Rupture (Client Dropout): Implications for Clinical Practice, Supervision and Training - our ref. no. 4837

Further to your application dated 26 September, you will be pleased to know that the Leicestershire Ethics Committee at its meeting held on the 7 November, 1997 approved your request to undertake the above-mentioned research.

Your attention is drawn to the attached paper which reminds the researcher of information that needs to be observed when ethics committee approval is given.

Yours sincerely

R F Bing
Chairman
Leicestershire Ethics Committee

(NB All communications relating to Leicestershire Ethics Committee must be sent to the Committee Secretariat at Leicestershire Health)
Appendix 2

Alison Tweed
Clinical Psychologist in Training
Centre for Applied Psychology
Leicester University
LE1 7RH

Consent Form

Study to investigate clinical psychologists' reactions to client non-attendance.

I agree to be involved in this research study and agree to be interviewed by the researcher, Alison Tweed. I am aware that I am able to withdraw from the study at any time and I will not be discriminated against in this, or in future studies.

I consent to the interview being tape-recorded and transcribed by the researcher. The tapes will be securely stored and listened to by the researcher only. The transcripts will be anonymised and the researcher will remove all identifying details in the transcripts.

As part of the researcher's written work, I agree for my interview transcript to be included as an appendix in her dissertation, which will be submitted to Leicester University in July 1998.

On withdrawal from the study, or after the interview has been transcribed, the researcher will remove the recording from the tapes.

Further details of the study can be discussed with Alison Tweed on (0116) 269 7380 (Tues. & Thurs.).

Signed

................................................................. (Participant)

................................................................. (Researcher)
Appendix 3

FOR INFORMATION

Alison Tweed
Clinical Psychologist in Training
Centre for Applied Psychology
Leicester University
LE1 7RH

Consent Form

Study to investigate clinical psychologists' reactions to client non-attendance.

I agree to be involved in this research study and agree to be interviewed by the researcher, Alison Tweed. I am aware that I am able to withdraw from the study at any time and I will not be discriminated against in this, or in future studies.

I consent to the interview being tape-recorded and transcribed by the researcher. The tapes will be securely stored and listened to by the researcher only. The transcripts will be anonymised and the researcher will remove all identifying details in the transcripts.

As part of the researcher's written work, I agree for my interview transcript to be included as an appendix in her dissertation, which will be submitted to Leicester University in July 1998.

On withdrawal from the study, or after the interview has been transcribed, the researcher will remove the recording from the tapes.

Further details of the study can be discussed with Alison Tweed on (0116) 269 7380 (Tues. & Thurs.).

Signed

........................................................................................................ (Participant)

........................................................................................................ (Researcher)
Appendix 4

Interview with 'Louise' 4/3/98

Alison Ok. I suppose I mean my main question really is what is it like, what is your reaction when a client doesn’t attend? And I am posing that to you as a question.

‘Louise’ There’s a real mixture. I mean I’m sometimes I am so busy it’s relief, you know, my initial response /And if it’s not someone I’m particularly worried about, if it’s someone who is usually a good attender and has appeared to just not, not turned up just once. Often. People just have one-offs where they don’t contact me or (.) I mean it makes a difference as well, sometimes people cancel and then that’s — real relief because I know that everything is ok and I can catch up on paper work. If it is someone who I know is doing fine and just appears to have not turned up then it it’s relief. If it’s someone who I am worried about who is maybe suicidal or then I will be quite concerned about it and usually write to them very promptly, or contact then very promptly. Asking them to get in touch and checking how they are. Sometimes if it’s a member of the group and it’s someone who has been extremely distressed the week before we like (.) kind of phone them. If we were very concerned. So it really does depend on the client. But (.) it varies, so it can be a real worry or it can be (.) a bit of a break really {laughs}.

Alison I think I mean from my interviews that I have done with other people, people seem to talk about sort of different types of non-attendance, that there might be someone who, who you never set eyes on they just never come. Or, somebody who just might come for an assessment, or
somebody that you have seen for a while and they just stop. Does it, are there different reactions that you can think about?

‘Louise’ Yeah. When we have different procedures here in terms of an initial, so that we have procedures laid down about what we do if someone doesn’t attend (.) an initial appointment. And we are all supposed to do a number of initial assessments every week. So, it is quite a continuous process of that and then there’s a lot of non-attendance.

And (.) what we are supposed to do is check the level of distress of the client with the GP, so whether they are / so if the letter implies that it is an urgent referral or that there’s quite a lot of distress, or it comes from kind of a psychiatric assessment then (.) we would be pursuing it quite (.) thoroughly and you know be more concerned about non-attendance. But there are quite a few referrals to the team where can the team imply that we are assessing, but are going to try and refer on because our remit is the chronic and enduring mental health problems.

So if it’s somebody’s who’s had anxiety for a few weeks then we are much more, the team procedure is to write and say (.) sorry you didn’t attend, please contact us in two weeks if you still want an appointment. Now a lot of people do, but the concern that goes with that is much less. It feels much more that maybe someone’s been pushed by a GP into coming and they actually didn’t want to attend. You asked about / if people have been coming a long time then my response is much more about who the person is and what’s happening therapeutically and what do I need to consider and what might be going on. So that really is focused on the client them self and what it might mean. The same in the group, you know. You can sometimes (.) be pretty sure that someone is feeling overwhelmed or that they want to avoid something that they have committed themselves to doing the follow week or that the process is that it is quite hard and then you’ve got an idea about what you might need to do in terms of contacting them or what support they might need whether you need
to phone or write (.) or whether they will come back next week anyhow, which is some people's pattern (.) really. So (.) that's the other form. And the other type you asked about is was/after initial assessment when you were just getting to know somebody and just taking them on. And because we have got such long waiting lists here that happens a lot too. And (.) in my experience it has often been because people have gone elsewhere or the crisis has passed. And if they have been on a longer term waiting list the worries less because (.) they have been evaluated as a non-urgent in the first instance. And they have been encouraged to go elsewhere. So again that is less worrying. And sometimes people come and for one or two but there's not the intensity there was when they were referred and there's quite a lot of non-attendance early on.

Alison: Yes. You mentioned that if a referral letter suggests that this person is in sort of great need to see you, that and if they don't turn up that you will get back to the GP. Is that to sort of find out how the client is or?

'Louise': Yeah. And whether the crisis is still there and whether the GP has been in touch or has any extra information whether the GP wants us to pursue it or whether the GP has put something else or. So that there's a real assessment. So if we had never met them then there needs to be a real assessment of urgency and need. And it could be that things have improved or they have got worse and often the GP is a good person to know what they want us to do. Or the psychiatrist who has referred them. So, that's sort of the procedure and the idea is the more information you have the better assessments. So do you send another appointment do you ring them up do you just say get in touch in two weeks. You can get sort of more information about the person themselves and how they might respond as well from the GP.

Alison: It sound like that information gives you an idea of of whether to send out a standard letter or something a bit more personal.
That’s right. Yeah. And whether it, we don’t tend to offer automatically second appointments if people don’t attend the first one, because people are so clogged up and we, we can get thirty odd referrals a week to the team. So the idea, you know if someone doesn’t attend, generally people don’t get a second offer, they have to get back to us. But you know, if it is urgent then there’s a feeling that maybe we need to offer another appointment or we need to pursue it more actively. That’s why really.

Right. You said that on some occasions you’ll phone somebody?

What might warrant a phone call as opposed to a letter?

(.) If someone, particularly if someone is a member of the group, or is a longer term client, where there is quite an established relationship, and they have seemed (.) you know in a lot of distress, maybe actively suicidal, or a very kind of crisis point, where the relationship’s important and they may need some encouragement or to talk something through before they can come back, if there’s something ongoing or maybe seems to be something that is actually happening in the group, or invariably you think they need a chance to talk it through before they’ll even bring themselves back here. Then (.) I, or one of my colleagues in the group would phone.

How often would you say that you would phone somebody (.) say in a week or something like that?

(.) In a week, it wouldn’t happen, in your average week. It would just happen occasionally. More often, it would be a letter, much more common.

And are there times when you would write, you’d send a letter that wasn’t a standard letter, that was maybe a bit more sort of direct towards the client themselves?

My letters would always be direct, the standard letters only go if I haven’t met people (.) or or they haven’t attended an assessment or if the first off therapy session. But if I have actually met the client then...
it would always be written to them. About specifically that was going
on (.), you know about having seen them, and when and what I was
thinking and how were they doing; so it would be much more
personalised, once I know somebody.

Alison

How would you, I don’t know if this is a hard question really. How do
you internally supervise after a non-attendance?

‘Louise’

(.) I don’t know. I mean I am not quite sure what the question means I
suppose. So, all I guess I would do is what I would usually do
following a session or a non-session which is, wonder about what had —
happened, see what sense I made of it, and what I thought I needed to —
do. Sort of go through those processes in sort of in terms of making a
decision and writing it up in the notes you know. I put a minimum —
amount of information in the notes, but as I did that I would be
thinking about it and wondering what was going on in the process —
Now I would already the client notes about what had been happening
the week before, before I saw them so I would have that in my mind —
and I would be thinking about what I had been planning to do and
whether that was part of (.) what I might have chosen and not to have
to do or what might have been going on with me or (.) even in their
lives, you know you might be aware of crises that you know are
coming up. For example, somebody who we see in the group has been
home to visit (.) one of her parents that she had only met a couple of
times in her life. Now (.) we knew that she was going to be (.) be in a
different place. This week and that she may or may not come so (.)
you know, then I would be thinking about what might have happened;—
and what she might need. — Considering —

Alison

It sounds like a process of reflection or on what has gone before and
your knowledge of the client, that’s what I can think.

‘Louise’

Yeah. I probably do less, I probably do less internal supervision on an
initial assessment or (.) yes, somebody who I’ve taken off the waiting
list, cos I have got nothing really to base it on except (.) maybe a
So that tends to be the ones that I am (.) they have less of an impact on me and they happen so often/that it sort of is almost part of my everyday life. And those are the times when maybe I don't worry about it in the same way anyway. Sort of, expect it to to a degree to happen quite regularly. I think all of our team expect a number of initial assessments not to attend.

Alison: Right. I mean (.) have you sought and do you seek supervision now for clients that don't attend?

'Louise': I have supervision (.) on all my work. So if I am concerned about a client who hasn't attended or if something comes up as a result of it, then I will take it to supervision. That isn't to say that every time someone doesn't attend I will take it to supervision. But all my clients are talked about. If they are ongoing clients it will come/it will part of my supervision. If it's someone I've never met it probably doesn't really come up very much — Unless I have reason to be concerned for I am wondering what to do. So when it is part of my ongoing work, it will come up in supervision. It's an important part of supervision. But there are people who (.) I guess just get swept along as part of the system and don't really get reflected on in the same way unless they contact or attend.

Alison: Yes. Do you, when you are thinking about say a session prior to one that a client didn't attend, sort of thinking back to the previous session. Are there any pointers that you can see that you think, or that that was a sign that they were sort of not likely to attend this time or?

'Louise': (.) I am hesitating because I am caught between groups and individual work. In the group there are definite signs which often are people — making statements about I'm not sure if this group is working for me or (.) sometimes being overwhelmed by the emotion that's triggered or leaving the room for a long period and sometimes not coming back in or being very reluctant to come back in. Although having said that quite often people will still come back despite those signs but they are
sometimes an indicator. And people who maybe find the group too confronting or too emotionally challenging. You can get an idea of the quite early on. In terms of their response to what is happening. In individual sessions, it doesn't happen that often. What I have found is once people are engaged in therapy, there is a tendency for them to at least contact me if they are not going to come. So I suppose the truth is it happens very rarely. So if the times like it even thought it's happened it's been about a month recently, certainly over the last number of months, it's been about muddled up times and things. Or a holiday or something you know has cropped up and they are going somewhere else. So I haven't, I can't think of recent examples where people have just who have been engaged in therapy just not turned up. Maybe in early sessions the signs might be a distinct lack of desire to be there, you know, maybe talking about someone having wanted them to come someone wanting them to change, or even feeling very stuck and wanting someone else to change but not really being there to work on their own issues. But I think that often happens very early on and people tend to opt out in sort of my experience here, quite early on if that's the case. I have only just realised how rarely it does happen with people who are committed to therapy and come regularly. And I usually know they are going to be here and they are.

Alison

Do you feel that the route of referral that the client comes through has an impact on their attendance?

‘Louise’

One thing that has struck me recently is many referrals to the group have come from outside this area and have been referrals specifically for the group. And have been through one assessment and then meet me for a further assessment. The attendance is very very good. So it like having that filtering process and being referred for a specific reason really has improved attendance greatly. And I
think that referrals that come through the psychiatrist who have already been assessed for this service, the attendance is better. And I sometimes, yeah. I think GP's sometimes refer here and the client's aren't that keen or you know, it's got a bit of a reputation locally and people don't want to be seen coming in here or things like that. And that you know, attendance isn't so good. So, yeah, I think it does make a difference.

Alison Right. Do you feel there are factors that might mean that a client doesn't attend or can't attend?

'Louise' (. ) One thing that seems to come up a lot are kind of life crises and practical issues. Another one is childcare. That there is no facility here for childcare. Many, particularly single parent families, it's impossible for them to come along with no one to leave the children with or (. ) a lot of people are concerned very about leaving their children with other people, especially because of their own experiences. So that certainly lost us some clients who might otherwise have come here. There's the pain of coming and having to talk about an experience, things that they have held onto for a long time. So it's too traumatic, it's too emotionally difficult and in some ways it is easier to stay where they are than do such painful work.

And the unknown, you know, as I have said this place has certainly got a reputation locally, and I think people assume that they will be labelled and other people say, you know, people will think I am mad if they see me coming in here and sort of, those kind of things put people right off. And sometimes people are worried that they will be locked away if they tell the truth about how they are feeling or, some of the things they feel like doing sometimes or whatever. So I think there are all sorts of beliefs and things as well that might get in the way.

Alison Right. I am just thinking of a scenario really. You've booked I suppose we could do this in two ways, an individual client for say one
o'clock and you now, the clock is creeping past to ten past one and you are thinking, I don't think they are going to come to this sessions. What sort of things might be going through your mind at that point?

(If it is at that point I would just be wondering whether they were or weren't going to come, and people, some people attend routinely late. That's an issue but So I would whether they are going to come.)

If it's not their usual behaviour, you know some people are obviously half an hour early, so at ten past one, I'd know. So, depending on who they were and what it was about, I would be thinking, thinking about what might be going on, where they might be, what might have happened last time. And (.) and deciding what, what I was going to do if they didn't attend, you know whether I was going to write a letter or was I going to contact them. Was I worried about what might be going on for them and what action was needed really. Right. Is there ever a (.) a time that you hold in your mind and you say, right after half an hour, that's it, you know I will do something else or?

No. I might, if there comes, if they're not here at say, ten, fifteen minutes past ten, I'd know. Like, drafting the letter or whatever. And I might be in the end doing other pieces of work, other pieces of paper work. But in my mind, if someone still turns up within their time slot, then I would, I would meet with them and talk with them for the remaining time. Assess how they were doing and what was going on. So I don't have a, I don't leave the building or do anything else that can't be interrupted. Just, that time is theirs really. Right. So you give them slot whether they are there or not really.

Yeah. But I might, I probably will catch up on bits and bobs in the meantime but, with the knowledge that it could be interrupted. I'm just sort of looking at my questions and I think we've mostly gone through the majority of them. I was just wondering (.) when you volunteered and I sort of gave a very brief outline, I suppose two
things really. What you thought and that and are there things that you feel you haven't had chance to talk about?

‘Louise’

( ) When you said on the phone what you were planning to do, I suppose I didn't have any real concept of what that might involve or what it might mean and ( ) I just felt fairly open minded about what you were going to have to say and I'll wait and see. In terms of ( ) whether there are things I have or haven't had the chance to say ( ) nothing really springs to mind, the thing that has struck me most from what I have said to you is that it's so different if it's someone I have never met. The difference for me is so very powerful. If it's someone I haven't met, to some degree it's a space and it means you know, I can do some work and if it's someone I have met, it has quite a lot of an impact and the process that it sets in motion is quite time-consuming and involves thinking about the client and what it means to what to do next. So the power of the relationship is very striking really. If I haven't got a face to put it I'm kind of not get so entrenched in ( ) having the worry and the concern about it and I suppose we have procedures and I can use those to some degree and say well, that's what I have to do anyhow. Whereas when it's someone that you have a meeting regularly there's much more of a personal wanting to know and wanting to check out. Someone who you are actually working with, it matters what's happening. Quite interesting. I have learnt from it.

Alison

Right. I know that some departments have a policy that they put in place that people actually opting-in, maybe getting information leaflets or something like that. Has that ever been a consideration in this department?

‘Louise’

We send out an initial appointment letter that says please contact us within two weeks if you are going to attend otherwise your appointment will be given to someone else. So the procedure is in place but the difficulty has been that so many people don't contact
I think because of the degree of distress that the people that we serve here are experiencing, it doesn't work. So all it does is give us an inkling of whether someone's going to turn up or not. But actually offering that appointment to somebody else doesn't feel very wise because you know, it's like people sometimes read the letter and don't take it all in and then they get the date in their mind and still turn up or, you know, they are not sure until the day whether they are actually going to come or not. So although try to do that to get a sign of whether someone is going to come, we have never taken it any further. People talk about it sometimes, but I think the worry is it that they will miss some of the people who really are in need. It's still up in the air and people still get frustrated by the number of non-attenders in the first instance but it's the only way that we can cut that down and not worry that some people missing are those that need it most. It's quite a difficult balance really between those.

Yeah. I think it will probably stay as it is. It used to be much more...procedure for a second appointment though. And I think that is the thing that has maybe changed a little bit as people now write a letter saying, please contact me if you want an appointment after a first non-attendance as opposed to saying, sorry not to have seen you, how about you come on this day and trying again. So people maybe got a bit more certain of the boundary there. And if someone is deemed to be in great need then they will still get offered a second appointment. There's nothing completely rigid there a sort of established procedures.

Yes. So would you tend to keep that person's slot open even if you hadn't heard from them? Just in case?

Yes.
'Louise': Yes. Very much so and that's pretty much what the whole team do. Just because so often they do attend, like a phone call is not much of an indication at all, you know sometimes people phone in and confirm and then they don't turn up. So it's very muddled and we send out standard questionnaires and sometimes we don't get them back and people turn up, and sometimes we get them back and then they don't turn up. So, nothing seems a very good guide as to whether that person will appear or not on the day. Yeah, we tend to keep the slots open and you know, those are the times when you know, maybe other bits and bobs get done if they don't turn up.
Appendix 5

Alison Tweed

Department of Applied Psychology
(Clinical Section)
Leicester University
LE1 7RH

21/4/98

Dear ,

Thank you for your participation in my research project. As I may have mentioned at the interview, I have enclosed an outline of my findings based on the analysis of the interview texts. I would be grateful if you would be able to comment on the findings from your perspective of being a participant in the research. This is a useful part of the qualitative research process and I can use your comments to re-shape my analysis.

As I was using a grounded theory methodology, I will give you a brief description of the analysis process, so you can orient yourself to the discussion overleaf!

The aim of grounded theory is to produce an understanding of a phenomenon under investigation through the development of theory that is grounded in the source material (e.g. interview texts). To achieve this, the interview data was split into small units of meaning which were named and coded. Groups of named units that were similar in nature were then subsumed within categories. These categories provide the building blocks to the final theory. Relationships between categories were then defined. As a final step in the analytic process, a core concept was developed and described. The core concept (hopefully) explains all of the data. It is the central feature under which the data fits.
In my discussion overleaf, I have described the core category first. I have then gone on to describe a process model. This tries to explain how the participants felt after non-attendance and what they did in response to the event. I have only presented the main categories in diagrammatic form.

The discussion is set out so that under the main category headings (underlined), I have outlined the intermediate level-categories and their sub-categories. The intermediate level categories are given in bold text; the sub-categories are given in italics.

It would be helpful if you could structure your comments using the following questions (please be honest!):

1. Does this model fit with your experience of non-attendance?
2. Do you feel anything has been omitted from the model?
3. Is there anything that does not make sense in the model?
4. Does the core category sound plausible?
5. Any other comments.

If possible, I would be grateful if you could send your comments to me within 2-3 weeks, or as soon as you can. Please call me if there is anything you wish to discuss (0116 269 7380 Tues. and Thurs.).

Awaiting your reply with thanks.

Best wishes,
The Core Category

Responsibility

From the analysis, the core category concerns responsibility. The clinical psychologist is responsible to his or her employer (the NHS), to keep accounts of client contacts and to work within the policies of this institution. The clinical psychologist is also responsible to his or her clients; to assess their needs and if appropriate, provide an intervention. Finally, the clinical psychologist is also responsible to him or herself. This is a responsibility to work to the best of his or her ability. Client non-attendance as an event, can impact on all these three levels.

Although not explicitly mentioned by the participants, the clinical psychologist is also responsible to the profession of clinical psychology.
The Process Model

The process model outlined below represents the impact of client non-attendance. Each of the major categories depicted in the model subsumes lower-order categories. These lower-order categories are directly related to the comments made by the participants and will be discussed further.

CORE CATEGORY

RESPONSIBILITY

PROCESS MODEL

BEING A CLINICAL PSYCHOLOGIST

NON-ATTENDANCE

EXPERIENCING DISRUPTION AS AFFECTIVE REACTION

LEARNING

RE-ORGANISATION TO EQUILIBRIUM

Model depicting the core category and the process of client non-attendance.
Being a Clinical Psychologist

This major concept encompasses the factors that form the clinical psychologists’ identity. These factors can mediate the impact of non-attendance, and form the basis by which non-attendance as an event is perceived. The three main factors drawn from the interviews are:

1. **Experience**
   During clinical psychology training and after qualification, the clinical psychologist has been gaining experience and knowledge. This includes experience of their clients (e.g. patterns of attendance), of the therapy process and of him/herself as a therapist. The clinical psychologist has also gained experience of non-attendance as a part of working life, knowledge of the referral route by which clients are sent and has experience of the practice of clinical psychology within the NHS (and possibly private practice).

These factors form a database of experience that the clinical psychologist can use to guide him or herself through working life. By having experience and knowledge of their client, the therapeutic relationship and the therapy process, the clinical psychologist may be able to anticipate or even predict that non-attendance will occur. This may enable the clinical psychologist to prepare and expect non-attendance. However, this process is less effective for anticipating client non-attendance at first appointment. Having never met the client, the clinical psychologist has only an outline of the client’s background and knowledge of the referrer to base their judgements on.

2. **Working within departmental procedures**
   This involves working within department guidelines and using procedures developed there. This may include procedures such as sending standard letters after non-attendance asking clients to contact within a set time period, contacting
referrers after non-attendance at first appointment and meeting quotients for a set number of initial assessments to be arranged per week.

3. **Working within NHS policies**
Part of being a clinical psychologist is working within the policies of the employer, in the participants’ case, the National Health Service. The clinical psychologist is required to follow certain procedures, for example detailing numbers of client contacts in a time period. The clinical psychologist must also be accountable to the employer and work within the statutes of the organisation.

Both categories 2 and 3 directly effect the clinical psychologist’s *workload*.

---

**Non-Attendance**

This is defined as a therapy event where the client does not attend for their arranged appointment and has not contacted the clinical psychologist to cancel their appointment beforehand. In some cases, the clinical psychologist has anticipated or predicted this event. In other cases, the event has not been predicted and it is unexpected. However, at some level the clinical psychologist has prepared him or herself for the session. The appointment has been arranged and the clinical psychologist is waiting for the client to arrive. Non-attendance has therefore provided the clinical psychologist with an empty session slot.

---

**Experiencing Disruption as Affective Reaction**

Non-attendance causes disruption to the session slot, as the time is no longer allocated for the purpose the clinical psychologist had intended.
Participants describe being in a state of flux at the beginning of the session slot. They do not know if the client is about to arrive, or whether they are not going to attend. There is a sense of agitation as they are trapped in the uncertainty of the situation. Finally, there is a realisation that the client has not attended, or is unlikely to attend. This will depend partly on the clinical psychologist's knowledge of the client, whether the client punctually attends, or has been late in the past. After realisation, the participants describe noticing an affective reaction. It is suggested that all non-attendance events will produce an affective reaction of some kind.

The affective reactions have been categorised into three groups that are not mutually exclusive; positive, negative and self-blame. Positive affective reaction includes relief that the client has not attended. Factors such as workload, or the anticipation of a difficult session may mediate this reaction. Negative affective reactions may include feelings such as worry and concern. Knowledge of the client (e.g. as a suicide risk) may mediate this factor. Thirdly, the clinical psychologist may experience self-blame and feel this as an affective state such as fear, or guilt.

From participants descriptions, non-attendance may also be seen as causing disruption at a personal level, impacting upon the clinical psychologist's perception of his or her own identity.

Re-Organisation to Equilibrium

In reaction to the disruption of the therapy session, the clinical psychologist experiences affective responses. The non-attendance event may also have impacted upon the clinical psychologist's self-view. As a minimal response to the disruption of the therapy session, the clinical psychologist needs to engage in certain strategies to reduce the disruption of the event. If the non-attendance event has impacted upon the clinical psychologist's self-view; he or she may also need to engage in additional strategies as a means of coping with the impact. In both cases, the clinical
psychologist is employing strategies to re-organise the disruption of non-attendance back to equilibrium.

As an initial step, the clinical psychologist engages in *internal supervision*. This is a process of reflection by which the clinical psychologist considers what needs to be done in terms of re-organisational strategies. Within this category of internal supervision, the participants discussed five main areas:

1. **Seeking answers**
   This involves asking why the non-attendance occurred and considering possible answers to this. If the clinical psychologist has seen the client on previous occasions, this may involve *reflecting on the previous session*. This includes, *client-directed reflection, reflection on the interaction and analysis of clinical skills*. If the clinical psychologist has little knowledge of the client, or is seeking additional information, he or she can *access the database of experience*. This involves using knowledge of factors that can influence attendance to hypothesise about the possible reasons for the non-attendance event. Again, this may include *client-directed reflection, reflection on the interaction, and analysis of clinical skills*, but at a more general, theoretical level.

2. **Attributing responsibility**
   This strategy is used most usually after experiencing self-blame as an affective reaction. If the clinical psychologist has seen the client on previous occasions, he or she may *accept blame* and conclude that he or she made a mistake that directly led to the non-attendance event. Independent of having seen the client previously, the clinical psychologist may also seek to *re-attribute blame*. This may involve the re-interpretation of self-blaming feelings by examining the evidence for the non-attendance event in a logical manner. Also, by using previous therapy successes as an anchor-point, the clinical psychologist can assess the validity of their self-blame.
3. **Decision to seek external supervision**

As part of the process of internal supervision, the clinical psychologist may decide that they need to discuss the non-attendance event with others. That is, internal supervision will lead to *external action*. This will most usually be the case with clients for whom the clinical psychologist has experienced a negative affective reaction, such as worry or concern. Included are such strategies as deciding to seek supervision at an *informal* level, by chatting with colleagues and receiving peer support. The clinical psychologist may also decide to seek *formal supervision*, discussing the non-attendance event in a setting specific to this purpose.

4. **Considering client-directed action**

As for the previous category, this aspect of internal supervision leads to *external action*. Client-directed actions have been separated into four categories:

a) **Contact client directly.** This includes contacting the client by letter or occasionally, by telephone. The mode of contact will be mediated by knowledge of the client and the therapeutic relationship. For example, the client may be sent a standard letter, they may be sent a non-standard letter, or may be contacted by telephone. However, contact by telephone is only used on rare occasions and some participants described never using this medium.

b) **Indirect contact.** This includes involving other professionals to liaise with the client. This strategy is most usually used in response to an assessment of the client’s risk (e.g. of suicide) or where the clinical psychologist feels concerned about the client. The involvement of other professionals may include them visiting the client, or providing further information regarding the client’s well being.

c) **Closure.** Here, the clinical psychology decides to discharge the client. This is usually in response to non-attendance followed by the client not responding to a letter.

d) **Action to reduce non-attendance.** As a means of reducing non-attendance in the future, the clinical psychologist may engage in this strategy. This
includes consulting with referring agents concerning appropriate referrals and developing new procedures, such as information packs and opt-in systems. Research and audit are described as the means by which new procedures can be developed and evaluated.

5. **Deciding what to do in the session space**

As the clinical psychologist has been provided with an extra period of time, he or she needs to decide how this time will be spent. Again, internal reflection leads to external action. This may include *looking after the self*, for example, having a rest or making a drink. The clinical psychologist may also decide to *manage their workload* and will spend the time catching up on paperwork and administration tasks. The type of work undertaken will depend upon the clinical psychologist’s speculation on whether it is felt that the client will attend late, or whether they will not attend at all.

**Learning**

The outcome of non-attendance and the therapy session not proceeding as planned is to act as a learning experience. The clinical psychologist may learn further about factors that can influence attendance, about their own working practices and about their clients. The clinical psychologist may also decide to change their working practices in some way in response to new understanding gained after the non-attendance event. Feeding back into the category of *being a clinical psychologist*, learning is a vital aspect of development. In many ways, by experiencing disruption to the regular therapy routine, the clinical psychologist can gain a deeper knowledge of the process of therapy, and the part that he or she plays in this encounter.