‘A missed session is still a session.’

How Child and Adolescent Psychotherapists understand the meaning of non-attended sessions with patients aged 18-25.

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ABSTRACT

This research project aimed to explore the individual experiences of Child and Adolescent Psychotherapists (CAPTs) working with patients aged 18-25 who, at times, do not attend - or 'DNA' - their sessions (as distinct from cancelling in advance). Current discourse around non-attendance largely focuses on its financial and emotional cost to services and patients; the aim of this project was to explore the deeper meaning behind non-attendance and the way it is understood in the context of psychoanalytic psychotherapy. Semi-structured interviews were conducted with qualified CAPTs and analysed using Interpretative Phenomenological Analysis (IPA). Findings revealed the feelings stirred up in CAPTs by their patients' unexplained absences, ranging from rejection to relief, with notable anxiety in response to an absent patient who is at risk of self-harm or suicide. These responses were often understood in the context of unconscious communication and projection. Clinicians emphasised the need for a certain degree of tolerance of no-shows with this age group, sharing the view that non-attendance does not necessarily equate to non-engagement. They highlighted the importance of the patient's communication being received and understood, which can in turn lead to progress in therapy. However, clinicians described the importance of limits and boundaries around non-attendance; this was in acknowledgement of limited resources, and also to encourage the patient to take responsibility for their therapy in order to aid development. Evident overall was the conflict felt by clinicians between the importance of working therapeutically with absence, and the pressure to discharge patients who aren't attending. The importance of making decisions on a case-by-case basis was highlighted. An understanding of the potential therapeutic significance behind young people missing sessions could hopefully contribute towards developing a more informed and tailored approach to thinking about non-attendance in psychotherapy and policy development, particularly given current pressures on services. It may also help to shape the way we think about how young adults engage with mental health treatment.

DECLARATION

I hereby declare that this thesis is entirely my own work, and that the ideas and written work of others have been identified and correctly referenced. This project has received full ethical approval from the Tavistock Research Ethics Committee (TREC). I confirm that I have taken all reasonable measures to ensure anonymity of the participants, their clients and institutions.

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I would like to express my sincerest thanks to the participants for giving up their time to take part in this research. I am extremely grateful to my research supervisor, Dr Danny Isaacs, for his ongoing support and encouragement throughout this project. Finally, I would like to express enormous appreciation and gratitude towards my family, for always being there.

CONTENTS

INTRODUCTION

A report by The Children's Society revealed that in 2016 approximately 157,000 Child and Adolescent Mental Health Service (CAMHS) appointments were missed by young people (Abdinasir, 2017). These non-attended sessions cost the NHS an estimated £45 million per year (Edbrooke-Childs et. al, 2020), while referrals to CAMHS escalated to over 1.2 million last year and waiting lists have risen by two thirds over two years (Hansen et al., 2021). It is little wonder, then, that the discourse around non-attendance focuses largely on the financial cost to services, and the emotional cost to patients on waiting lists. In other words, missed appointments are typically regarded as waste (Anderson, 2015) and the NHS has set out to reduce its 'did not attend', or 'DNA', rates across all public healthcare settings.

While the reasons behind this attempt to clamp down on non-attendance are evident, it seems that the generalisation of this approach and the lack of consideration towards the individual meaning or possible therapeutic significance of non-attendance is problematic. It also appears that on an organisational level, no distinction is made between failure to attend a first appointment, drop-out, disengagement, or missed sessions as part of ongoing therapy treatment. Furthermore, while attempts to reduce non-attendance in therapy, such as sending text message reminders, can have a positive effect (Filippidou et al., 2014), their negligible impact and the fact that DNA rates remain high suggests that the reasons for missing therapy appointments can run deeper than a patient simply forgetting (Clougha & Caseya, 2014).

Understanding the deeper, or unconscious, meaning behind an individual's behaviour and communication lies at the heart of psychoanalytic psychotherapy – an approach that can feel at odds with generic policy making. As I will explain further in the next section, I am curious

as to how psychoanalytic psychotherapists understand the meaning of, and work with, non-attendance whilst also managing the service-related pressures mentioned above.

My focus will be on psychotherapy with 18-25-year-old, or 'young adult', patients. I was curious to understand how Child and Adolescent Psychotherapists (CAPTs) make sense of missed sessions amongst this population of patients who are, often for the first time, responsible for bringing themselves to therapy rather than relying on their parents. I wondered about the relationship between this developmental stage of early adulthood, the dependency evoked by engagement with psychotherapy, and the young person's attendance at sessions. Furthermore, this age group can be a somewhat 'missing' population in both mental health research and clinical services, which have historically divided patients into either child and adolescent (0-18) or adult categories. The once-rigid distinction between these age groups in mental health services is becoming more nuanced, with the transitional period between one's teens and early adulthood now seen as a developmental stage in its own right (Syed & Seiffge-Krenke, 2013); this is reflected in the NHS's Long Term Plan, which commits to changing its policy in order to allow CAMHS to offer treatment to young people up to 25 years old, rather than 18 (National Health Service, 2019).

I will now further describe the aims of this research and what I perceive to be a conflict in psychotherapy services when it comes to working with DNAs, using an illustration from my own professional setting.

Professional background and context

My interest in this subject has developed primarily across four years working as a Trainee Child and Adolescent Psychoanalytic Psychotherapist in a specialist psychotherapy service for adolescents and young adults. Although the service accepts referrals from age 14, the majority of young people who receive psychotherapy are aged between 18 and 25 (as under 18s are usually seen in local CAMHS). The service is currently one of the few in the country which offers specialist treatment to patients in this age bracket.

After each scheduled session with a patient, we log the 'outcome' of the session in our computer system. If a patient has not turned up, this is registered as a 'DNA'. This relates specifically to an unexplained no-show, and is different to when a patient has cancelled the session in advance.

During the time I have worked in the service, I have noticed the prevalence of DNAs in work with this age group (especially compared to my work elsewhere with younger children, who are brought by their parents), and have grown curious as to the reasons behind this. I have also been interested, in clinical supervision and team meetings, to hear the depth of emotional responses that clinicians can experience when patients don't turn up, including feeling concerned, worried, frustrated, anxious and sometimes even relieved. It is worth noting here that listening to one's own emotional responses to a patient is an integral part of being a psychoanalytic psychotherapist. From the very start of our training, we are taught to consult the feelings a patient stirs up in us, referred to as countertransference, as they can offer an insight into the emotional experience of the young person. Heimann (1950) suggests that the therapist's feelings can act as a key to the patient's unconscious, while Klein (1946) noted the way that the patient may attempt to rid himself of unwanted or disturbing feelings by

unconsciously projecting them onto the therapist. Both Heimann and Winnicott (1949) noted that it is essential that the therapist has worked through her own infantile conflicts and anxieties, so her countertransference can be observed rather than acted out in an unhelpful way. I will explore this further in my Literature Review.

Case example

Claire[1] is a 22-year-old patient who came to see me for weekly psychoanalytic psychotherapy for two and a half years. Claire was one of four siblings, and our work often centred around a theme of her feeling ignored, unseen and inadequate, and of not believing that anyone could really help her. For the first six months of her therapy, Claire would either come to her sessions in a very anxious state, or not turn up. Sometimes she would 'disappear' for several weeks at a time, with no warning. My attempts to contact her via email were ignored. Her absences had quite a profound impact on me – I was left wondering what had happened to her, anxious about her state of mind, feeling inadequate as a therapist, and even unsure whether I would ever see her again. Through discussion with colleagues, I was helped to see that by not coming to her sessions, Claire was not only re-enacting childhood experiences of not feeling seen or helped, but was unconsciously giving me an experience of feeling forgotten about and not good enough. What's more, she was making it very difficult for me to help her. I was able to gradually bring this into focus with Claire, helping her see the role she was playing in her experience of feeling ignored or not helped, and beginning to put some of her previously intolerable feelings into words. Subsequently, she began to attend her sessions much more regularly. It felt as though she had needed me to have these difficult-to-bear feelings myself, before we could begin to understand them together.

[1] Pseudonym used. Patient details are a composite of a number of young people I have worked with, to ensure anonymity.

Alongside these important interactions I was experiencing with Claire, I was aware of pressures within the service to reduce DNA rates, not least because it does not get paid for missed appointments (whereas it does for cancelled appointments). An awareness of the 'ever deepening, ongoing and enduring crisis' of the NHS, identified by Baraitser and Brook (2021), hung over the time I spent waiting for Claire to turn up, as did the knowledge that there were patients on our waiting lists who'd been waiting almost a year to begin treatment. And yet, I felt hopeful that persevering with Claire's therapy could lead to significant progress for her.

It appears to me that there is a conflict. On the one hand, mental health services are trying to reduce DNA rates in order to not waste precious resources, including clinicians' time. And yet, conversations with CAPTs working with older adolescents and young adults highlight a shared feeling that missed sessions are an inevitable, and in fact even important, part of the work with this age group.

I was curious, therefore, to further understand this tension from the perspective of the clinicians working directly with these patients. I wanted to explore CAPTs' individual thoughts and feelings about their experience of working with young adult patients who don't turn up to sessions, and to learn more about how they manage the conflict between working therapeutically with absence and respecting service-related pressures. I was interested to find out if they have, at times, made the decision to terminate treatment, and, if so, how this decision was made. I was also curious about what they considered to be the contributing developmental factors for non-attendance in older adolescents and young adults in particular.

LITERATURE REVIEW

I began this project by reviewing the existing literature and research related to my chosen subject. In doing so, I identified a number of key areas which felt important to explore:

- Missed appointments
- Improving engagement
- Emerging adulthood as a developmental stage
- Psychoanalytic psychotherapy with patients aged 18-25

Literature review strategy

To conduct my literature review, I first established the resources available to me. Through the Tavistock and Portman Library, I was able to access a number of databases via EBSCO. Of these, PsychInfo and PEP Archive were most useful to my current search. I then identified the key search terms for the themes listed above. This process developed as I noted the key terms written at the beginning of relevant articles, which helped me to expand my search over time. Here is an example of search terms used:

Missed appointments	Psychoanalytic Psychotherapy	Young adults
Missed sessions	Psychotherapy	Older adolescents
Non-attendance	Psychotherapeutic	Adolescence
DNAs	Psychoanalytic	18-25 year olds
Did not attend		Young adulthood
Engagement		Emerging adulthood
Absence		

I then used Boolean Operators – terms such as AND, NOT and OR – to narrow or widen my searches. For example, using 'non-attendance' AND 'psychotherapy' AND 'young adults', I hoped to only find literature which related to all three topics. It took time to sift through the results, and some trial and error to work out which search terms yielded most relevant results. I excluded research where the focus was on therapeutic interventions other than psychoanalytic or psychodynamic therapy, or where findings focused on drop out rates or non-engagement where the patient hasn't engaged at all with treatment. I also found it helpful to review the reference list at the end of relevant articles, which led me to further papers.

Exclusions

I have focused primarily on research conducted in Western societies. I primarily draw on British literature, but where relevant empirical research is lacking in the UK, I have noted findings from projects further afield.

It is also worth noting that there is a large body of literature exploring DNA rates at adult psychiatric appointments, and an even bigger range of research into no-shows at all other kinds of medical appointments. There has also been investigation into the reasons behind failure to engage in mental health treatment in the first place. However, besides acknowledging where my research sits within this context, I felt this was significantly different to missed appointments as part of ongoing psychotherapy treatment with older adolescents and young adults and not relevant enough to the topic in question to include here. This review focuses on literature more directly pertinent to the research question, which explores the way

psychotherapists understand the meaning of DNAs in psychoanalytic psychotherapy with young adults.

N.B. In the literature review I will use the pronoun ‘he’ when referring to the patient or young person, and ‘she’ when referring to the therapist, for clarity.

Missed appointments

Missed sessions are costly to health services because of the administrative and clinical time lost, as well as the opportunity cost of not treating other patients (Leavey et al., 2011). Mitchell & Selmes (2007) found that adult patients miss approximately 20% of scheduled appointments for mental health treatment (almost twice the rate of other medical specialties), while a report by The Children’s Society found that approximately 157,000 appointments across all Child and Adolescent Mental Health Services were missed by children and young people in 2016 (Abdinasir, 2017). This concluded that, as well as the emotional cost for young people not getting the treatment they need, these missed appointments cost the NHS over £45 million per year.

Predictors of non-attendance

There is a body of quantitative research into predictors of non-attendance amongst adults and children at mental health appointments. For example, Fenger et al. (2011) found that no-shows in treatment amongst adult patients were predicted by both demographic (less stable personal and social situations, and lower education levels) and clinical factors. Non-attendance among adult psychiatric patients has been found to positively correlate with the severity of their mental

illness and lower social functioning, as well as having a negative impact on their recovery; patients who missed appointments are more likely to have been admitted to in-patient care 12 months later (Killaspy et al., 2000). Similarly, Bell's 2001 review of studies investigating factors that predicted failure to engage with or drop out of therapeutic treatment for adults with bulimia nervosa showed that co-morbid borderline personality disorder was the predominant explanatory factor.

Where younger patients are concerned, Arai, Stapley & Roberts (2013) looked at DNA rates for children under 10 accessing healthcare, including CAMHS services, and commented on the responsibility for non-attendance being carried by the parents in this case. They found that predictors of DNAs included socio-demographic and socio-cultural factors, practical or logistical reasons (e.g. transport), referral waiting times and administrative error. Parental and child anxieties about attending, as well as social deprivation, have also been found to contribute to non-attendance in child mental health services (Minty & Anderson, 2004). Trautman et al. (1993) found that 10-18-year olds who had attempted suicide prior to starting therapy were less likely to keep appointments than those who hadn't. The same study found that girls missed more appointments than boys, and patients of ethnic minority were also less likely to attend sessions. Piacentini et al. (1995) studied the relationship between age, gender and treatment attendance in adolescents who had come to outpatient therapy after suicide attempts, finding that non-attendance was higher for older adolescents, particularly males. Cohen and Hesselbart (1993), who examined the age, sex, socioeconomic status and urbanicity of residence of young people aged 12 - 21 using mental health services in New York state, found a significant drop in mental health service use for those aged 18 - 21. They speculated on whether this age group tends to 'fall between the cracks', as opposed to younger adolescents or adults, and wondered whether this was linked with lessening parental responsibility or control. More recently,

O'Keeffe et al. (2018) found that older adolescents receiving therapy for depression are more likely to drop out of treatment later on, suggesting that therapy may conflict with the late-adolescent need for autonomy, as well as linking this to older adolescents being responsible for their own attendance rather than relying on parental support to attend. The quality of adolescent patients' participation or involvement in therapy has been found to be the most important determinant of outcome (Shirk & Karver, 2006).

As can be seen, research tends to categorise patients into either adult or under-18 age groups. Although there may well be 18-25-year-old patients encompassed by studies into adult therapy, they are often not considered as a patient population in their own right and therefore conclusions cannot be drawn with regards to that age group specifically. As O'Keeffe et al. (2018) touched on in their findings, there may be developmental particularities which ought to be considered. Furthermore, much of the above-outlined research into non-attendance does not appear to make the critical distinction between failure to engage in the first place, and patients missing follow up appointments, nor does it specify between cancelled sessions and DNAs. There also appears to be a tendency to equate missed sessions with non-engagement, rather than considering DNAs as a form of communication, and therefore potentially an engagement of sorts, even if the patient is not physically present in the room. Additionally, many studies regarding non-attendance in therapy tend to focus on drop out, rather than on patients who might miss sessions but remain, to some degree, engaged in treatment.

Xiao et al. (2017) noted this gap, observing that that there has been almost no research into the impact of multiple non-attended appointments during the process of therapy, as distinct from therapy dropout. They identified a distinction between a cancellation - which they feel evidences patient effort and engagement - and a no-show. In a quantitative study, they

compared the effects of cancelled and DNA appointments on overall symptom reduction and rate of change in psychotherapy amongst adult patients. Their results suggested that no-shows had negative impacts on the scale and rate of symptom change, however the authors cautioned against interpreting this as indication that patients who miss sessions are 'doomed', as the size of the effect was small. Cancellations, on the other hand, did not appear to have an impact on therapeutic outcome. Interestingly, DNAs within the first 3 sessions of treatment had a far larger impact on the therapeutic outcome than no-shows later in the therapy, leading the researchers to speculate about the necessity for attendance early in the therapy to allow for a good therapeutic alliance to develop between therapist and patient. They concluded that 'attendance appears to be an area of research that could unearth important strategies to improve effectiveness of mental health care', and point out that future research should address these limitations by examining the impact of different reasons for poor attendance.

Meaning behind patient non-attendance

Some of the above studies speculate as to the possible meaning behind patients not attending, however more in-depth research is scarce. One such qualitative study was carried out by Leavey et al. (2011) who explored non-engagement through interviews with adult patients (including young adults) referred to eating disorder clinics. They discovered that while patients initially offered practical reasons for not coming to appointments, it was quickly found that profound social-psychological problems and ambivalence towards receiving help lay at the heart of their non-attendance. Of particular relevance here is perhaps the finding that traumatic childhood experiences were associated with deep mistrust, defectiveness, low self-esteem and emotional deprivation. One 25-year-old patient considered her failure to engage in therapy to be linked with insecure attachments in early childhood and her inability to trust others or make

positive relationships. Depression and anxiety also emerged as significant underlying reasons for non-attendance, often in relation to fear of leaving the house and finding it difficult to function socially, as did unmet expectations of therapy. The importance of the therapeutic relationship also came to the fore, with patients needing to feel safe enough to come back. The authors reflected that non-attendance does not necessarily equate to not needing help, and commented that pressures on public services could contribute to lack of follow up with these patients.

Perhaps most closely aligned with this present study was a piece of research conducted by Binder et al. (2008) in Norway, in which psychotherapists were interviewed about their experience of working with alliance ruptures in the therapeutic relationship with adolescent patients. Missed sessions were viewed as a rupture in the contact between patient and therapist, and not necessarily as a sign that contact was getting poorer or that the patient was disengaging. Signs of 'not wanting therapy' were interpreted by therapists as a communication from the patient that the relationship felt difficult; when attendance fluctuates, therapists said they place importance on understanding *why* it feels so difficult for the patient to come to the session. Patient non-attendance was seen as a 'common challenge', and therapists felt it could ultimately be beneficial as it presents the young person with an opportunity to re-establish contact – this in turn has the potential to be a positive and therapeutic learning experience.

Therapists' experience of non-attendance

How it feels for therapists when their patient doesn't turn up, and their thinking about the possible meaning behind this, has thus far tended to be explored in psychoanalytic literature and individual case studies rather than through empirical research. Therapists have written

about the way they often use their own experience and emotional responses as a way to understand the patient's internal world. This use of one's own feelings as an insight into the patient's state of mind and the way they are relating to the therapist is commonly referred to in psychoanalysis as countertransference (Heimann, 1950), and a number of studies support its effectiveness as a tool in therapy (for example, Hartkamp et al., 2002; Hennissen et al., 2020).

Gordon (2000) writes how young adult patients not turning up for sessions can leave him feeling frustrated, devalued, helpless de-skilled and worried, as well as guilty when his colleagues are working and clinical hours are so in demand. He considers the dilemmas facing the clinician whose patient doesn't show up – is it better to persevere and hold the space open, or to offer the vacancy to someone else on the waiting list? – emphasising the importance of making a decision based on the individual patient rather than being led by policy. Casement (1985) considers unexplained absences as a communication of feelings which the patient may not yet feel able to put into words. He offers the following vignette:

> The patient (whom I shall call Miss G.) had been traumatized as a child by her mother's repeated absences, in hospital with cancer, and (at the age of four) by her mother's death. […] Miss G. frequently failed to turn up for sessions; and for a long time her silence at the beginning of sessions had exerted an enormous pressure on the therapist to speak first. In this phase of treatment the therapist listened closely to what she was thinking and feeling, during these silences or unexplained absences. She realized she was left not knowing what was happening to the patient and (on some occasions) she even wondered whether she would ever see Miss G. again. [..] the therapist came to wonder whether her patient was making her feel a sense of abandonment and uncertainty, similar to that which Miss G. had probably felt during her mother's

> unexplained absences in hospital, and after her eventual death. […] Listening to what the patient was making her feel in this way, the therapist was able to interpret to Miss G. her awareness of how unbearable it must have been when she was so often left in this state of not knowing what was happening to her mother. […] The patient was gradually able to acknowledge that this made sense to her. (Casement, 1985; 89).

In this excerpt, the therapist uses her own emotional experience to begin to understand what the patient might be communicating. Similarly, Rustin (2009) describes the powerful feelings that can be initially evoked in her by late adolescent and young adult patients, observing that the complex histories of some young people who skip sessions may be communicating that it is, for them, better to be the forgetter than the forgotten.

In a study by Anderson (2015), clinicians of different disciplines in CAMHS were interviewed about their experiences of non-attendance with children and adolescents. They spoke of the conflicting feelings stirred up in them by DNAs, including having to balance both relief and rejection, and spoke about how they try to understand no-shows within the context of treatment and what is going on for the patient. They also spoke about the incongruence between the corporate perspective of missed appointments and their own psychological understanding and clinical judgements. This is a conflict that I hoped to further explore in this study, through the lens of work with young adult patients, rather than children and younger adolescents.

There are also references to missed sessions in qualitative studies exploring other aspects of the therapists' experience of offering psychotherapy to young adults. Two qualitative studies by Werbart et al. (2019) explored psychotherapists' reflections on psychoanalytic work with young adult patients; while not specifically focusing on DNAs, missed sessions were identified

by therapists as being one way in which patients regulate the distance and intimacy between themselves and their therapist. They described feeling highly impacted by this experience.

Improving engagement

I will briefly outline research into improving engagement in psychotherapy to illustrate other angles from which DNAs have been thought about. Researchers have begun to explore how to better engage young people in mental health services, precisely to reduce non-attendance. Green et al. (2012) interviewed service users aged 16 and above for suggestions; common ideas included using an age-appropriate approach for younger patients that reflects youth culture and lifestyles, encouraging development of autonomy, taking a personal approach, the importance of empathy and authenticity in clinicians and of creating a safe environment. The majority of studies into improving engagement have thus far looked at the adult population. Sheeran et al. (2007) looked at motivating factors for attending psychotherapy among adult patients at a mental health service in Yorkshire. They found that participants who formed implementation intentions (an 'if-then' plan), rather than simply setting goals for treatment, were more likely to attend their initial psychotherapy appointment. Jayaram et al. (2008) used a before-and-after study design, in which they sent prompting letters to all adult patients due to attend psychiatric outpatient clinic appointments for a period of six months, which resulted in an average non-attendance rate of 17%; this was significantly less compared to 27% in the same six-month period the year before. However, studies into the impact of letter or text message reminders on attendance have yielded mixed results: sometimes this has been shown to decrease DNA rates (Filippidou et al., 2014; Boland & Burnett, 2014), whilst at other times to have minimal influence (Clougha & Caseya, 2014). Furthermore, these studies were carried out with adult

patients in psychiatric and community mental health settings, where the offered treatment was not psychoanalytic psychotherapy.

Emerging adulthood

I will now explore the literature on young adulthood. I will first present an overview of the external and internal processes that a young person is likely to be contending with as he transitions from late adolescence into early adulthood, including a reflection on a more psychoanalytic perspective on this stage of development, before presenting existing studies into the mental health of this patient population.

Becoming an adult in a changing world

While we may once have considered adolescence and adulthood as two distinct and chronological developmental stages, with a well-defined path from one to the other, psychologist Jeffrey Arnett has coined the term 'emerging adulthood', proposing that the period between the ages of 18 and 25 should be considered as a developmental stage in its own right (2000). Numerous writers have developed this idea, highlighting this stage of life as being unique in its positioning between the dependency of adolescence and the normative responsibilities of adulthood (e.g. Syed & Seiffge-Krenke, 2013). Because of changes in demographic, socio-cultural and employment economics, as well as technical advances and globalisation, adolescents now travel into adulthood in uneven ways, creating contradictory circumstances: some young people may be positioned as more adult in some aspects of their lives, and yet in other areas continue to depend on parental support (Zarrett & Eccles, 2006; Briggs, Maxwell & Keenan, 2015). Interviews with young Americans have supported this,

revealing a subjective sense of having departed adolescence but of not quite having entered adulthood (Arnett, 1998). Briggs (2019) agrees that adolescent development now extends into adulthood, and observes how upheavals in the social world and radically changing contexts for young people mean that existing theories of adolescent developmental processes lag behind experience. Neurological literature complements this; scientific evidence shows the adolescent brain as being 'under construction' until early adulthood (Arain et al., 2013), and has been used to support the NHS's most recent Long Term Plan to expand CAMHS support to reach young people aged up to 25, rather than the existing cut-off age of 18 (National Health Service, 2019).

More recent statistics from Western industrialised countries show that it is towards the end of one's twenties and into early thirties that young people more fully assume adult responsibilities such as becoming financially independent, entering more committed relationships and living independently (Settersten & Ray, 2010), while meta-analytic research indicates a delay in identity development and great variation with which mature states of identity are accomplished (Kroger, Martinussen, & Marcia, 2010). While for many young people this transitional period can provide a welcome opportunity to experiment with one's place in the world before 'settling down', Catty notes that delays to starting adult life are not always a good thing; she considers today's adolescents as 'a generation pre-emptively disadvantaged', the forecast of their adult lives predicting difficulty finding work, buying a home, and even retiring (2021, p.189).

Emotional development

Waddell (2002, 2018) has written extensively about the emotional and psychic journey from adolescence to adulthood. She notes that one of the chief undertakings of this period is to establish a mind of one's own. Highlighted in the literature is the internal conflict within a

young person between dependence and independence, caught between the desire to be a grown up *and* remain a child (Harris, 1969). While this conflict can be present throughout the whole of adolescence, Waddell writes that it is during the approach to adulthood that one's internal strive for separateness collides with external reality, as the young person leaves school and the parental home (2018). She considers the introjective processes taking place during this time, as the adolescent is required 'to relinquish external figures of dependence and attachment and to install a version of them within' (2018; p.216).

What has come before? Coren (1997) describes adolescence as a period of turmoil and contradictions. The end of latency and the start of early adolescence is marked by physical changes to the body and a resurgence of sexual curiosities and Oedipal rivalries which may have been lying dormant during the primary school years. Towards mid-teens, a young person may become more ambivalent towards authority, and increasingly self-preoccupied as he discovers his separateness from others (Coren, 1997). This has been referred to as a 'second individuation process' (Blos, 1962), mirroring the psychological dilemmas of separation experienced in infancy and toddlerhood. The infant's development of his sense of self takes place in the context of his dependence on the primary caregiver (Mahler & McDevitt, 1982); similarly, the adolescent's quest for autonomy and independence involves both a railing against and also a falling back on parental support and guidance (Coren, 1997). How the adolescent experiences these separations can echo the nature of his much earlier weaning, and his first encounters with the world beyond his primary relationships (Klein, 1957; Youell, 2006). Delinquent and aggressive behaviours in the adolescent can be understood as attempts to push away the parental figures, but also as means to defend against the unbearable feelings of loss that come with separation. Peer relationships become crucial to identity development; as a

young person tries to develop his sense of self, he can face conflicting wishes to be both normal (part of a collective 'we') and different (a separate, individual 'I') (Coren, 1997).

Alongside hope and expectation, therefore, the young person faces inevitable wrenches and losses as he crosses the threshold into adulthood. He must definitively let go of childhood, as well as the idealised version of himself and others, in favour of the real. Arnett (2000) and Waddell (2018) reflect on the importance of the young person's capacity to mourn what is being let go, both externally and internally, in order to successfully move forwards.

The development of an internal capacity for intimacy and an involvement in romantic relationships is another salient task in late adolescence and early adulthood (Barzeva et al., 2021). In theory, relationships move from an early-adolescent individual level of sexual and romantic cravings to a dyadic level, in which relationships are emotionally intimate and where aspects of self and other are negotiated and balanced and where individuals start seeking and entering longer-lasting, more committed relationships. However, this is thought to have been complicated in recent decades by the previously-mentioned societal risks, instabilities and uncertainties, which can delay the negotiation of longer-term, committed relationships (Shulman & Connolly, 2013). Back in 1968, psychoanalyst Erikson identified the crisis of adulthood as being one of intimacy versus isolation – a conflict exacerbated today by the impact of online and social media, which have transformed young people's patterns of friendship, ways of relating to others and experiences of intimacy and separateness (Briggs, 2019). The relationship between social media use and the emotional development and mental health of adolescents and young adults is yet to be fully understood (Bozzola et al. 2022); recent research has supported both the positive and negative impact of the online world on young people. For example, use of online networking sites has been shown to strengthen adolescents' social

connectivity both on- and offline (Reich et al., 2012) and can help increase their sense of belonging (Allen et al., 2014). On the other hand, social media use has also been shown to correlate with depressive symptoms (Ma et al., 2021) and anxiety (Muzaffar et al. 2018).

These contrasting views are reflected in psychoanalytic literature. Graham, for example, writes that ordinary processes of separation and individuation simply 'migrate' into the digital domain, with young people 'learning and testing themselves in this space' (2013, p. 273). Lemma, meanwhile, argues that this migration constitutes a loss of the significance of the physical body in the experience of being separate, and therefore alters the relationship between internal and external reality. She writes that the 'painful awareness of the given body and of bodily separateness may be sidestepped', and that digital life 'bypasses the need for the psychic work necessary for understanding that inner and outer reality are linked rather than being either equated or split off' (Lemma, 2015, p.60).

Perhaps most important to note is the fact that adolescent emotional development is hardly a linear process, nor is it neatly contained within the teenage years. Just as the journey into adulthood is uneven on a societal level (as described earlier) so it is on an emotional level; certain adolescent developmental tasks continue into young adulthood, with a fluidity between infantile and more mature states of mind. Blos captures this rather evocatively in the passage below:

> I view my growing attention to adolescence as being a determined approach to the two opposing shores of a river, trekking my way closer from the vast hinterlands of childhood and adulthood to the connecting rushing waters between those two shores, namely, to adolescence. Having arrived at this bridging passageway which joins the

> two shores, I set up my observation post in the middle of this crowded thoroughfare, watching the endless traffic of people moving back and forth from both sides—some rushing ahead, then stopping and waiting in indecision; some retreating, then suddenly changing direction altogether (Blos, 1989).

And what is to follow in later adulthood? Waddell (2002) writes that emotional development – or the act of 'growing up' – is a lifelong process. Rather than becoming immune to infantile impulses and longings, adulthood could be seen as a journey towards 'knowing and understanding those undeveloped aspects of the self and, as a consequence, being alert to their potential effects, particularly their destructiveness' (p.197). Klein (1946) defined maturity as an increased capacity to live in the depressive position, which involves perceiving the other as *genuinely* other as we engage with the outside world of work, of community and of society at large (Waddell, 2002).

Early adulthood and mental health

What brings young adults to therapy? This period in life has been found to be a time of increased psychological strain and tendency towards depressed mood (Kuwabara et al., 2007), the period described by some as a quarter-life crisis (Robbins & Wilner, 2001). The peak age of onset of mental illness is during adolescence and early adulthood (Kessler et al., 2005; Solmi et al., 2022), and according to a report by the Office for National Statistics, almost a quarter of 16-24-year-olds had symptoms of anxiety or depression (2020). What might be the cause? While many emerging adults adjust to the separation from their families and begin to consolidate the necessary ego capacities to support them during their adult lives, some may struggle to adapt, posing obstacles in the developmental path and leading to distress, anxiety

and depression (Szajnberg & Massie, 2003; Syed & Seiffge-Krenke, 2013; Palmstierna & Werbart, 2013). Pushed to separate from parental figures and move forwards in life, young people can feel inadequate if they find themselves still in need of guidance and support (Chused, 1987). For some, the timing of these transitions may be out of kilter with their development, posing the challenge of how to fit in with a social world they are not ready for (Youell, 2006). Ordinary transitions, such as finishing school and leaving home, have been shown to increase depressive symptoms in some young adults (Galambos & Krahn, 2008). A study of religious beliefs amongst emerging adults found that young people can struggle as they reject the ideologies of their parents without yet having found anything more compelling to take their place (Arnett & Jensen, 2002), and feelings of meaningless and hopelessness are expressed more often than they were historically (Jacobsson et al., 2011). What's more, the lessening of parental guidance and the wish for new experiences has been shown to increase risky behaviours such as substance misuse, unprotected sex and dangerous driving (Bachman et al., 1996). Briggs (2008) writes that upheavals in the social world and the changing contexts for young people mean that a new sense of turbulence has become apparent, with heightened states of anxiety and a fear of loss of control. He later (2019) describes new possibilities and vulnerabilities relating to the body, sexuality and gender, and observes the challenge to clinicians working with this age group of how to understand both the enduring aspects of development and the impacts of new factors.

Psychoanalytic psychotherapy with 18-25-year-olds

Access to mental health support

It can be particularly difficult for young adults to access mental health support. Until very recently, the aforementioned view of emerging adulthood as a transitional, 'in between' developmental stage has been mirrored in services: most CAMHS services have offered treatment until a young person turns 18, forcing an often-premature transition to adult services. Many still do, as the journey to achieve the NHS's 10-year long-term plan to extend CAMHS treatment for those up to 25 will take time (National Health Service, 2019). For a long time, young adults, particularly those with complex needs, have been at risk of falling through the gap (Singh & Tuomainen, 2015). There are only a few services in the country which bridge the gap, supporting young people through what many clinicians consider to be an arbitrary cut-off point between adolescence and adulthood. A systematic review by Paul et al. (2015) supported the development of programmes that address the broader transitional care needs of emerging adults and their mental health needs. A number of transition services have been established, such as *Minding the Gap* in Camden, North London, which was set up with the aim to address this issue and assist with decision-making regarding which adult service best suits young patients in this transition.

Psychoanalytic psychotherapy with young adults

Psychoanalytic psychotherapy is a treatment which aims to address the thoughts, feelings and wishes that lie beyond our conscious awareness but which nevertheless affect our behaviour (Lemma, 2016). There is a growing body of evidence to suggest that a psychoanalytic approach

is effective with both children and adolescents (Fonagy & Target, 1996; Urwin, 2009; Schachter & Target, 2009; Weitkamp et al., 2014; Goodyer et al., 2017). Most recently, Midgley et al. (2021) conducted a narrative synthesis of the evidence base with regards to children and adolescents, which highlighted the growing evidence supporting the effectiveness of this therapeutic approach with children and young people presenting with a wide range of clinical issues.

As already mentioned, Arnett's (2000) idea of emerging adulthood as a developmental stage in its own right is incongruous with the majority of research into psychoanalytic psychotherapy, which seems largely to divide patient populations into 0-18-year-old and adult categories. That said, my literature review revealed a collection of studies from the Young Adult Psychotherapy Project in Sweden, which was set up to address this paucity of research into psychoanalytic psychotherapy with young adults in particular. Among their researchers, Jacobsson et al. (2011) asserted that 'more seldom is research focused on young adults'.

The findings of studies within this project have so far supported the long-term effectiveness of psychoanalytic psychotherapy with young adults. Research has addressed areas such as treatment helping to overcome depression (von Below et al., 2010), significant, positive shifts in symptoms across long-term treatment (Lindgren et al., 2010), changes in the internal representations of one's parents (Werbart et al., 2011), patients feeling less troubled by their problems post treatment (Jacobsson et al., 2011) and positive correlation between secure attachment to the therapist and improvement of symptoms (Lilliengren et al., 2015).

Palmstierna & Werbart (2013) advocate the importance of thinking about therapeutic work with 18-25-year-olds as unique from work with other age groups. They note how the

developmental tasks of young adults may conflict with the process of therapy, being, as they are, in a transient life situation, preferring to focus on action rather than reflection. They stress the importance of therapists being more flexible with the therapeutic frame to take this into account. Similarly, Philips et al. (2006) suggest that young adults may lack motivation for reflecting upon themselves, as they are often more focused on the external world and situations they find themselves in:

> Often they do not want to be caught up in transference feelings that pull them backwards in threatening ways. […] Working carefully and tactfully, using judicious interpretations, the therapist can help the young person to take further curative steps. This involves recognition of aspects of themselves and others that have been warded off and looking back at the threatening past. It also involves reliving feelings in the here-and-now of the consulting room, and being able to tolerate these feelings. It means trying new ways of acting, instead of the habitual ones. (Philips et al., 2006:90)

Numerous writers share their observations of the dynamics which can appear in psychotherapy with young people who are still in the process of separation from parental figures and where there may be a strong ambivalence towards dependency. Winnicott cautions therapists to 'expect defiant independence to alternate with regression to dependence' (1963, p.244), while Shefler (2000) describes the challenges of persevering with treatment when resistance to dependence on the therapist overcomes the young adult, fearing that long term commitment will squelch their independence. Briggs, Maxwell & Keenan (2015) note that some patients can hardly bear to stay in a room with a therapist, whilst others arrive at the first session almost as if they have brought their suitcase ready to move in. A psychoanalytic psychotherapist is likely to be thinking about the transference in these instances, observing the way the patient is

relating to her, and reflecting on who she may unconsciously 'be' in the patient's inner world in that moment (Freud, 1905; Alvarez, 2012). For example, Catty (2021) suggests that a young person who misses sessions may be wishing to test their room to manoeuvre in relation to adult control, perhaps experiencing the therapist in the transference as a controlling parental figure. Similarly, Bent-Hazelwood (2020) recalls her work with an older adolescent with a history of being sexually abused by an authority figure, who used sporadic attendance in therapy as a means of staying in control of the intimacy with and dependence on the perceived adult in charge.

Gaps in the literature

In this literature review I first provided an overview of findings related to missed appointments in mental health services, and the findings of quantitative research into the predictors of non-attendance. I then drew attention to the small amount of research which has been carried out into the meaning behind non-attendance, before highlighting some of the psychoanalytic literature into the way clinicians might think about and experience patients missing sessions. I briefly outlined the research into methods used to improve engagement in psychotherapy, before turning to the literature on emotional development in emerging adulthood and what has been discovered in relation to young adults' mental health. Finally, I gave an overview of psychoanalytic theory and the evidence base of psychoanalytic psychotherapy with young adults.

It is clear from my review of current literature that there is a need for research into the way CAPTs make sense of unexplained absences in psychoanalytic psychotherapy with young adults. Evidence shows that young adults present unique challenges and dynamics in (and

indeed out of) the therapy room; it feels important that research distinguishes this age group from others, and I would suggest that generalisations cannot be made from research with younger adolescents and adults. Furthermore, although a number of studies explore predictors of missed sessions, there is very little research into the deeper meaning behind patient DNAs, let alone those which consider the unconscious processes which may be at work, and which lie at the heart of CAPTs' thinking. Perhaps most close to this were the aforementioned studies by Anderson (2015), which explored the way clinicians from different disciplines experience non-attendance in CAMHS, and Binder et al.'s study (2008) which explored therapists' views on ruptures in the therapeutic alliance with adolescents. I hope to further contribute to the findings of these studies, with a focus on young adult patients, in psychoanalytic psychotherapy in particular. It is also worth noting that many studies mentioned above were carried out in Sweden and America, among other countries, and it cannot be assumed that results can be translated across cultures and healthcare systems. I am curious as to how UK-based CAPTs negotiate the specific funding pressures they face, and how their clinical thinking and practice around missed sessions is impacted by the context in which they work.

I hope that this project may contribute to a better understanding of the meaning behind patients missing sessions, in particular in the context of psychoanalytic psychotherapy. In turn, this could impact the way services approach or develop policies around missed sessions, as well as how they might support young people to attend. It may also reveal that, to some extent, missed sessions can be an important and perhaps even helpful aspect of psychoanalytic work with this age group.

METHODOLOGY

Overview

In this chapter, I will describe how I designed my study, and explain why I chose certain research methods to analyse the data. I will also reflect on potential research problems that I have held in mind.

First, I will briefly revisit the aims of my project. I wanted to explore Child and Adolescent Psychotherapists' experience of working with young adult patients who don't turn up to (or 'DNA') sessions. I was hoping to further understand:

- What the experience is like for a clinician when their patient doesn't turn up, and how this is different to when a patient cancels a session.
- How the clinician makes sense of the non-attended session, and the significance of these missed sessions in the therapeutic treatment as a whole.
- How therapists think about the missed sessions in relation to older adolescence/young adulthood.
- Clinicians' feelings about working with non-attended sessions in the context of public healthcare where resources are often at a premium.

Recruitment

I chose to interview five qualified CAPTs. I felt this would provide me with a rich enough scope of individual experience, whilst being a small enough sample to be able to analyse each

interview in sufficient depth. (I made the decision not to interview trainee CAPTs, in order to increase the chances of participants having more substantial experience working with patients, and a more in-depth understanding of working psychoanalytically. Although several of the participants did speak about patients seen during their training years, I felt they were nevertheless discussing this from the viewpoint of subsequent experience.)

Once I had gained full ethical approval to carry out my study via the Tavistock Research Ethics Committee (TREC), I approached CAPTs working in services which I knew accepted referrals (not necessarily exclusively) for young people aged 18-25. It was important that these services were NHS or publicly funded, as I hoped to explore whether this had any impact on clinicians' experience of non-attendance. Although some clinicians I interviewed also work privately, I made it clear that I was interested to hear about their work in public healthcare settings. I approached services via their administrator, asking that my request be passed on to clinicians. With this initial contact, I provided a Participant Information Sheet (see Appendix 2), in which I explained my professional role and briefly outlined the purpose of the study. I also provided a short background to my interest in my chosen area of research. I explained that participation in the study would involve a semi-structured interview of approximately one hour, and gave an idea of the sort of topics I would be interested to hear about. I made clear relevant data protection details and that participation in the project was voluntary.

Of the CAPTs who took part in the study, two were male and three were female. They were of a range of ages and had a range of years of experience. All were at least five years out of training. Two participants worked in a charity-funded service for adolescents and young adults, two worked in NHS generic CAMHS services, and one participant worked in a specialist NHS service for adolescents and young adults. I had a professional relationship with one participant,

who was my clinical supervisor. For my data analysis, I have given each participant a pseudonym: Peter, Eleanor, Daniel, Natasha and Sophie. For the purposes of anonymity, participants' details, for example their gender and cultural background, may not necessarily be reflected by these pseudonyms.

Design

I used Interpretative Phenomenological Analysis (IPA) to approach my study because I was interested in clinicians' individual experience of their work. IPA is a phenomenological approach, rooted in philosopher Husserl's (1859-1938) belief that subjective experience should provide the grounding for any subsequent objective scientific account of the world (Smith & Nizza, 2022). The method aims to get as close as possible to the lived experience of an individual, and how they make sense of that experience. It is an interpretative method, in which both the researcher and participant are interpreters: the participant tries to make sense of what is happening to them, while the researcher tries to make sense of the participant's sense making. This is known as a double hermeneutic approach (Smith & Osborn, 2003). Furthermore, as Smith & Nizza write, IPA is particularly helpful with regards to 'illuminating ambiguity and tensions in people's reactions' (2022, p.4). I anticipated that there could be some dilemmas and conflicting feelings for CAPTs around working with patients who miss sessions, and I wanted to use a method that would allow me to explore the nuances of this. IPA is also thought to be a useful method of data analysis for clinical practitioners to design and make sense of their interactions and interventions with clients (Smith & Nizza, 2022), which closely aligned with my aims for this research.

IPA is idiographic in nature; that is, it concerns itself with the particular, and any subsequent generalisations are grounded in this (Eatough & Smith, 2017). Because of IPA's focus on the individual, usually drawing findings from small sample sizes or individual case studies, there are inevitable limitations to the generalisability of findings. Alternative qualitative approaches, such as Thematic Analysis (which explores patterns or themes in data) or Grounded Theory (which seeks to generate theory from data) can address larger sample sizes, however this can preclude a deeper exploration of the intricacy, dilemma and nuance of individual experience which was a key focus of my research.

As is usual for an IPA study, I gathered my data using a semi-structured interview. To design the interview schedule, I initially thought about which areas of the participants' experience I wanted to explore. I felt that it was important for the clinician to have at least one patient in mind to discuss during the interview, as this would allow for more depth of reflection and discussion. I then designed the questions in an open way using terms such as 'how' or 'what', in the hope that participants would feel able to expand their answer beyond a simple 'yes' or 'no', feel able to speak freely about their experience and not feel there was anything specific I was expecting them to say (Smith & Nizza, 2022). I planned to gently guide them if I felt they were straying too far from the topic of interest, but otherwise to listen and allow their narrative to unfold. I thought of a few prompts for each question, in case the participant needed some help thinking about their answer. Figure 1 below illustrates the full interview guide and prompts.

Figure 1

1. How would you describe the difference between a DNA and a cancellation?
   Prompt: Do you feel there is a clear distinction between the two?
2. Can you tell me about an experience working with a patient with whom missed sessions have been part of the work?
   Prompts: How did you feel during the missed session time? How did you spend the session time when the patient didn't turn up? How did you feel afterwards?
3. How did you make sense of the missed sessions?
   Prompt: Did you notice any patterns or significance with regards to when the patient didn't attend? Do you think any issues relating to the patient's background were significant in relation to the patient missing sessions?
4. How do you feel the missed sessions played a role in the therapy, if at all?
5. Can you think of a second case example of a patient who has missed sessions?
   Prompt (if the participant can't think of a second case): Do you have any further general reflections on DNAs with this age group?
6. How do you feel the patient's age or stage of development is related to the non-attended sessions?
7. Have you had to think about whether to continue or withdraw treatment? If so, what factors have played a part in that decision?
8. What is the policy in your service around DNAs? What are your thoughts about this?

I conducted all my interviews within a 12-week period. I offered to speak with participants before the interview if they felt it would be helpful, but none of them took up this offer. I emailed them a brief outline of the interview schedule – this didn't include the specific questions, but the broad areas which would be covered in the interview – and a consent form, which they completed and returned ahead of the interview. I let them know that I would like them to tell me about a particular patient they've worked with, to give them a chance to think about this in advance. I said that meeting in person was preferable, offering to come to their place of work, but that we could conduct the interview online using Zoom if this was easier for them. I held two interviews in the participants' place of work, two interviews online on Zoom, and one participant chose to come to my place of work. I have not identified in my findings

which interviews took place in person and which took place on Zoom, in order to protect anonymity, however I will reflect at a later stage on the possible impact on the data of the different interview formats. In each case, the participant and I had a quiet, private space without interruption. I held a practice interview with my research supervisor in advance, to familiarise myself with the set-up and to test the flow of my interview schedule.

Although I had a printed copy of my questions with me in the interview, I made sure that I was familiar with them beforehand, so that I wouldn't have to look down too much and could instead engage with the participant in a more natural way, such as being able to make eye contact and pay attention to what they were saying. At the beginning of the interview, I gained each participant's consent to audio-record the interview. I reminded them of the topic of my research, let them know that I was interested to hear about their experiences and encouraged them to talk openly and freely, explaining that there are no right or wrong answers. This offered the chance to exchange a few words at the beginning and, I hope, to make them feel more at ease. I also clarified that each participant was familiar with the term 'DNA' and that this terminology was used in their service (all five participants said that it was).

I transcribed the interviews myself, rather than using software, as this helped me to better engage with the content. After each interview, and also as I transcribed them, I wrote down any observations about non-verbal aspects of the interview, including the participant's tone of voice and body language, and anything noticeable I had felt in response.

Data analysis

Once I had completed and transcribed all five interviews, I began the process of analysing my data. I started with the first interview, and analysed this fully before moving on to the next. I explored the interviews in the order in which I had conducted them, so that I was able to observe any developments in the way they naturally occurred over time.

For each interview, I followed the data analysis steps recommended by Smith & Nizza (2022). I first read through the interview transcript whilst listening to the audio recording. This enabled me to re-engage with the experience of the interview and the participant, and to re-familiarise myself with their tone of voice and the way they expressed themselves. During this initial read-through, I noted down any observations or thoughts in the margin. I then went through the transcript a second time in more detail, continuing to note down my thoughts.

On the third reading of the transcript, I began to create a list of Experiential Statements. This involved writing down short statements pertaining to the content of the interview, either summarising the point I felt the participant was making, or interpreting or inferring from the material. I noted the line numbers of the relevant section of the interview transcript, in order to make it easier to find illustrative quotations when writing up my findings.

For each interview, once I had a full list of Experiential Statements, I typed these up, printed them and cut them into strips. I laid these out on a large surface, and clustered them into groups. At this stage, there was some repetition between themes, and so I trimmed them down as I went, sometimes combining two or more themes into one, or discarding duplicates. For each cluster of statements, I devised a Personal Experiential Theme which I felt captured the essence

of that cluster. By the end of this process, I had four Personal Experiential Themes, each with four to six Experiential Statements within them. An example of this can be seen in Figure 2.

Figure 2

Theme	**Line number**
Theme 1: Feeling left alone with a difficult experience	
Feeling despair, rejected, despondent, foolish or a failure	21, 131, 213
Feeling alone and in need of support from colleagues	25, 35, 309
Frustrated that the patient isn't there to think together	43
Discomfort making it hard to get on with other things	208
Fantasising about a better therapist	210
Response depends on the individual patient	54
Theme 2: Understanding DNAs as unconscious communication	
DNA is an unconscious communication or a need to work through something	14, 19, 43, 104
Feeling like something is being done *to* her (I)	15
Can be a sign that the patient is struggling	56
Patient testing her capacity to survive her attacks	107
Patient's earliest object relationships being enacted in the therapeutic relationship	102, 141
Theme 3: Belief that DNAs can be an important part of treatment	
Surviving the DNAs was an integral part of the work	92, 268
Progress only made after the patient had been allowed to DNA	167, 200, 268
Challenging to advocate for the importance of DNAs	282
Projection is an ordinary part of adolescent communication	68, 333
Theme 4: Acknowledging the reality and helpfulness of limits and boundaries	
Importance of limits only after the emotional experience has been had	109, 167
Dilemma between receiving the communication and not wanting to collude with the patient	151
Setting limits led to a positive shift in the treatment	173

Increase in the pressure to discharge patients and fill the space	280
Strict policies not always adhered to in reality	278, 286
DNAs as a sign the patient isn't ready for therapy	300

Once I had repeated this process with all five interviews, I began to look through all the participants' themes to find commonalities or links between their interviews. Sometimes these were shared opinions or experiences, at other times perhaps opposite views which I felt could be brought together within the same overarching theme. I gradually began to devise Group Experiential Themes which I felt represented all the participants' interviews, with sub-themes within these to bring in further detail. I reviewed these with my supervisor as part of the process of clarifying the final themes. I ended up with four Group Experiential Themes, each of which had two or three sub-themes (these will be detailed in my findings).

Psychoanalytic theory

Given that my research question pertains to psychoanalytic psychotherapy with young adults, that the participants are psychoanalytic psychotherapists, and that I am interested in the way the meaning behind missed sessions is understood in the context of psychoanalytic psychotherapy, it is worth highlighting that I will be viewing the data through a psychoanalytic lens. This felt particularly relevant when considering the way CAPTs reflected on their countertransference in relation to patients, and the unconscious communication and projections behind their patients' behaviour. It also shaped some of my more interpretative themes, linked to the way I felt participants were communicating with me during the interview. I will explore this in more depth in my Findings and Discussion chapters.

Reflexivity

In light of my own personal interest and experience related to this research topic, I have been careful to remain mindful of the ways in which my own views might have influenced my interviewing technique and data analysis, and to try and mitigate this where possible. I kept a reflexive diary throughout the process, with the aim of observing the impact of my own subjectivity and expectations, and I have also made use of discussions with my supervisor to help me with this. However, as Biggerstaff (2012) writes, the qualitative researcher is never 'neutral' – by definition, IPA embraces the concept of intersubjectivity. The researcher aims to put herself in the position of the participant in an attempt to understand the world from that person's perspective, whilst also inevitably viewing the data through her own subjective lens. At its heart, the use of IPA involves a commitment to understanding phenomena of interest from a first-person perspective and a belief in the value of subjective knowledge for psychological understanding (Eatough & Smith, 2017). I will explore this further in my Conclusion chapter.

FINDINGS

Four Group Experiential Themes were devised from the analysis: 'An emotional response', 'Trying to make sense of absence', 'The value of DNAs' and 'Facing reality'. These were then split into sub-themes. See Figure 3 for details.

Figure 3

Group Experiential Theme	**Sub-themes**
An emotional response	- Sitting with difficult feelings - Not knowing - Feeling left alone
Trying to make sense of absence	- Unconscious communication - Controlling the boundaries - Avoiding dependency
The value of DNAs	- DNAs can be ordinary and important - Making a case
Facing reality	- There's a limit - Being realistic - Striking a balance

N.B. In the presentation of findings, participants are referred to interchangeably as 'participants', 'therapists' or 'clinicians'. Patients are referred to as 'patient' or 'young person'.

Overview of themes

The first Group Experiential Theme – 'An emotional response' – refers to the therapists' observations of how they feel in response to their patient not turning up. All of the participants spoke about the difficult feelings that can be evoked, such as feeling forgotten about or rejected, with some commenting on how hard it can be to sit with these emotions *(Sitting with difficult feelings).* Linked to this was the experience of the unknown that inevitably comes with an unexplained absence *(Not knowing)*, with participants noting how this is very particular to a DNA, as opposed to a cancellation where they might have at least some information about what is happening for the patient. Some spoke about how this sense of unknown can leave them feeling de-skilled, while others described feeling preoccupied and unable to get on with other things. Common amongst the participants was a feeling that they have been left to do all the work on their own *(Feeling left alone),* holding the desire to 'get the patient back' in order to make sense of things together, as well as their need for support from colleagues to manage these experiences.

The second Group Experiential Theme – 'Trying to make sense of absence' – refers to the ways in which participants try to understand the meaning behind their patients' DNAs, often using their own emotional responses as an insight into what the patient may be communicating. All of the clinicians conveyed how they think about the unconscious and non-verbal communication behind an unattended session *(Unconscious communication)*. Some thought about DNAs as the patient's response to the boundaries of the therapy, or an attempt to secure a place inside the therapist's mind *(Controlling the boundaries),* while some reflected on absence as a means to regulate intimacy and dependency *(Avoiding dependency).*

The third Group Experiential Theme – 'The value of DNAs' – refers to the way that the participants appeared to want to make it clear how important a role DNAs can play in psychoanalytic psychotherapy with older adolescents and young adults. They spoke about non-verbal communication and projection as being ordinary aspects of adolescent interaction and emphasised their belief that DNAs can play a crucial role in work with young people; they said that a period of non-attendance can be an important stage of the treatment, provided it can be thought about and worked through with the patient *(DNAs can be ordinary and important).* Also striking was the extent to which the participants appeared to want to make a case for this, alongside a wish to advocate for DNAs to be tolerated in the services where they work *(Making a case).*

The final Group Experiential Theme is 'Facing reality'. This encompasses the way participants spoke about the helpfulness of setting limits around DNAs, and how they cannot be endlessly tolerated *(There's a limit).* They spoke about the importance of being realistic when it comes to limited resources and long waiting lists in the public sector, as well as the external demands and pressures in young adults' lives *(Being realistic).* Finally, what became clear were the dilemmas participants face when it comes to working with DNAs, and the need to hold in mind many different, and often conflicting, factors *(Striking a balance).*

I will now explore each theme in more depth, giving examples from the interviews to illustrate my findings.

An emotional response

Sitting with difficult feelings

All of the participants made it clear that challenging feelings can be stirred up in them when their patient does not turn up for a session:

> *[…] when I was in the room when she hadn't arrived, you know, the more rational, logical kind of thinking wasn't so available, you know, I was the rejected, useless, not good enough therapist, that was very much the feeling in the countertransference at those times. And very hard to deal with.* (Sophie)

> *I felt it was a sort of powerful message really to me, their clinician, their therapist, often left me feeling neglected, unwanted […]* (Daniel)

Sophie and Daniel spoke about painful feelings relating to rejection and neglect. In Sophie's use of the word 'countertransference' and Daniel's description of it being a 'powerful message', both therapists acknowledged that their feelings are, to some extent, rooted in their relationship with the patient and the unattended session. And yet, as Sophie pointed out, this more 'logical' thinking is harder to access in the moment, which suggests the emotional experience is no less real or 'hard to deal with' even if it can be more rationally understood in the context of the therapy. She painted an image of waiting in the room for the patient to arrive, which further illustrated her feeling of rejection. Daniel's sense that his experience can be a 'message' from the patient suggested that, on some level, he feels the young person intends for him to feel this way, even if the intention is unconscious.

While Daniel and Sophie placed greater emphasis on feelings of rejection and neglect, Natasha and Peter described how they can feel forgotten about, or dropped from the patient's mind:

> *[…] the sense that she forgot completely about me, and the DNA was, in her [the patient's] mind, just forgetting, and it was possible to think about […] the sense of being dropped* (Natasha)

> *Did you think about calling in? Did you think about me at that point? […] So what, essentially […] what have you internalised of me? 'Cos actually it seems like you don't think about me at that point* (Peter)

Here, Natasha and Peter shared a feeling that they have not been held in mind by the patient. Natasha can have the sense that she has been dropped, or forgotten about completely, although she conveyed that on a deeper level it might not be as simple as the patient merely forgetting about her. Peter also considered what might be going on in the patient's mind, left questioning the extent to which he has been internalised by them. He gave the impression of feeling, at times, almost dehumanised, as though the young person is unable to acknowledge him as a person at all:

> *It's different isn't it, when someone just texts 'I can't come to my session' or 'I'm not coming to my session', you know, no name […] of the person they're going to see* (Peter)

Peter appeared to question whether he even exists in the patient's mind in the gap between sessions, which could perhaps mirror the patient's anxiety that they do not exist in their therapist's mind during this time.

Eleanor and Peter also communicated feeling frustrated and annoyed at the wasted effort – both physical and emotional – that they have put in to a session which is then not attended:

> *There can also be frustration about, um, you know, perhaps having, I come from quite a long way, so having come in early, got up very early and arrived and there being no patient. […] there is the sense of the kind of resources and the kind of time being wasted.* (Eleanor)

> *Of course, I had fantasies of her being in terrible states and sometimes she'd come back and she had been in terrible states, and sometimes she hadn't actually. On one occasion she'd been on holiday and hadn't told me, 'oh yes I'd booked it months ago, I've been to Spain'* (Peter) (underlined words expressed with notable emphasis)

Eleanor spoke more explicitly about her frustration at having made the effort to be there for the patient, only to find that her time and effort have been wasted. Her description of having got up early and travelled a long way emphasised the considerable work she devotes to the patient beyond the boundaries of the session time, which in turn exacerbates her frustration when the patient then doesn't make use of the session offered. I felt that Peter's irritation was rather more implicit: he didn't name it directly, yet his tone of voice and physical gestures conveyed annoyance as he described having worried intensely about his patient's wellbeing, before learning she'd actually just been on holiday.

All the participants highlighted the intense anxiety and worry provoked in them when a patient who is at risk of self-harm or suicide does not attend their session:

> *Perhaps when there's a lot of risk involved, um, and, you know, that that kind of turning up is evidence of them still being ok, alive, and the kind of DNA actually having quite a profound effect […]* (Eleanor)

> *[…] filled with anxiety, you know, I've worked with really risky patients that then when they don't come, you know, I sort of think have they killed themselves?* (Peter)

> *There was really something about getting in […] especially if you are risky because you are letting the therapist feel like what is happening?* (Natasha)

The powerful impact of a risky patient's unexplained absence was made clear through participants' use of words such as 'profound effect' and 'filled with anxiety'. The therapists described their association between the patient's absence and their possible death: Peter articulated his fear about whether a patient has killed themselves and Eleanor implied a similar concern when she said that the patient turning up is evidence they are still alive. Natasha described an experience of something really 'getting in', as she can be left wondering 'what is happening'. She said, as though speaking to the patient, 'you are letting the therapist feel' – as observed previously with other participants, there was an implication here that there can be intention behind the patient's communication, even if unconscious.

It is worth noting that Daniel and Peter both referred to more positive feelings which can arise in response to a patient's absence – something that the other participants did not raise directly:

> *I should say something about how what a relief sometimes a DNA can be as well, for you as a clinician. Sometimes you need a breather, and a DNA is welcomed. In some ways that's the patient managing the temperature in a sort of helpful way.* (Daniel)

> *[…] sometimes I'm actually very pleased when they cancel and DNA because let's say, I don't know, one example, I had a DNA with, er, let's see I think he was about 20, 21, who was almost isolated in his room for years and years and years and then he didn't come because he'd gone to the pub with a friend [smiles] and actually I was really pleased about that, and I thought that is a bit of progress […]* (Peter)

Here, Daniel associated his relief with his own need for a break (a 'breather') from the therapy and suggested this might also have been the patient's intention. One might also wonder whether Daniel was alluding to his relief at being afforded a break in his busy schedule. Peter, on the other hand, suggested that a DNA can be a sign of a positive developmental shift in the patient, which in turn can leave him feeling pleased for them.

There was a noticeable absence of positive feelings expressed by the other participants. Of course, this could suggest that they don't feel such emotions, however it made me wonder whether it felt hard to confess to, or even to be in touch with, feelings of relief or pleasure about a patient not turning up. Perhaps they felt worried about what this might reveal about their feelings towards the patient, or about themselves as a clinician.

Not knowing

The participants described an experience of sitting with the unknown, noting how this is unique to DNAs when compared to a cancellation (when the patient gets in touch in advance).

> *I think I also felt a bit uncomfortable thinking well where is he, what is he doing, you know […] I think there is that sense of being in the dark.* (Eleanor)

> *While perhaps with cancellations they give you a little bit of peace of mind, in the sense that you might know what is happening or why they are not attending. With a DNA there is something about needing to keep them in mind, even though they are not there* (Natasha)

> *You also need to think about why this is not…they're not coming and that you don't know why, and you can make all sorts ... of course, I had fantasies* (Daniel)

Eleanor, Natasha and Daniel all conveyed an experience of being left with questions about why the patient isn't there. In the absence of explanation, Daniel's mind can turn to 'fantasies' about what is happening to the patient, and Natasha's description of a cancellation offering 'peace of mind' suggested that, conversely, there can be a feeling of uncertainty and unknown with a DNA. Eleanor equated not knowing with feeling 'left in the dark', which can leave her with a sense of discomfort. Furthermore, it seemed that for Peter, Eleanor and Sophie, this uncertainty can lead to doubts about their capacity as therapists:

[…] was it that you completely got things wrong and you think there's been a lot of understanding and actually there wasn't? (Peter)

Um so perhaps at times there's also that kind of sense of, you know, is this helpful, perhaps some kind of questioning, you know, is there, are things a bit stuck, am I a good enough therapist? (Eleanor)

I think my mind was often filled with fantasies about this much better contact that she, in my mind, had had with her first therapist […] you know, I was the rejected, useless, not good enough therapist (Sophie)

There seemed to be a shared sense of self-doubt and of feeling de-skilled in the face of not knowing. Peter can start to doubt how much he really understood the patient in the previous sessions, wondering whether he had 'completely got things wrong', while Eleanor and Sophie could both experience concern about not being a good enough therapist. For Daniel, these anxieties seemed to manifest in a sense of humiliation in front of colleagues:

It becomes a sort of team matter, becomes public. […] Well it becomes humiliating as well, doesn't it? You're sort of presenting this case you can't get hold of. […] It became very shaming for him and for me. Er, because I used to have to take him to the team and talk about how I couldn't really contain this child, or this young person. (Daniel)

Here, I felt Daniel was conveying a sense of powerlessness. He felt that his patient not attending, and his not knowing why, somehow reflected his inability to 'get hold of' the work, which in turn left him feeling humiliated and ashamed in front of his colleagues. He linked this

with a feeling of having lost control of the therapeutic frame, as his communication with the patient can transfer onto email rather than taking place in the therapy room:

> *[…] you end up in knots because … the therapy leaves the treatment room and ends up online almost. [Slight laugh].* (Daniel)

For Sophie and Natasha, not knowing why a patient hasn't arrived can be preoccupying, which makes it hard to get on with other things during the session time:

> *I think on the whole I never felt I could get on with other things. There was a way in which she was very present in her absence, in this very uncomfortable kind of way.* (Sophie)

> *With a DNA there is something about needing to keep them in mind, even though they are not there, you know you can't go on and do something else […] if you have a message to say I'm not coming, you know that they're alright […] if it's a good reason, you know, you feel ok I can go on with my work, I might have a nice break* (Natasha)

It seemed both therapists were describing an experience of the patient being very present in their mind, despite not having come to their session. There was a striking sense of the patient still being there in some way, as though the therapists can feel somehow 'in' the session with the patient for the duration of the session time, despite not being physically in the room together. I wondered whether the clinicians might, at times, be left holding something on behalf of the patient, made all the more difficult when they don't know why they haven't turned up. Natasha contrasted this with occasions where she *does* know the reason for the patient's

absence, indicating that her inability to get on with other things might be linked to her discomfort with the experience of not knowing.

On a more interpretative level, I wondered about each participant's way of managing the experience of not knowing that is stirred up by DNAs. One seemed very prepared for the interview, appearing to wish to make it clear to me that he knew the questions I would ask and had already thought about them. Others were noticeably self-deprecating about their 'performance' in the interview, expressing anxiety about not making sense or not being prepared enough. It occurred to me that these anxieties might be indicative of something feeling exposing or vulnerable about talking about patients who DNA, perhaps linked to the aforementioned experiences of feeling deskilled, humiliated or not knowing. I also wondered about the conviction with which some interpreted the meaning behind their patients' absences (which I will come to later), as though perhaps wishing to reach for explanations and reason as a way to manage the anxiety of not knowing.

Feeling left alone

Participants conveyed a sense of being just one person in a relationship where there should be two, left alone with difficult feelings and tasked with doing all the thinking by oneself.

> *As a therapist that's sitting waiting for a patient that hasn't turned up, you're on your own with all that.* (Sophie)

Sophie portrayed a stark image of 'sitting waiting', highlighting the sense of aloneness and of being 'without' the other. Natasha and Peter shared a sense of being the one doing all the work, denied the opportunity to think together with the patient about what is happening:

> *There is still work happening in your mind, in your thinking about them, you can give them something back, but you are doing all the work if you are the one, if you don't see them how do you, you know, transfer the work […]* (Natasha)

> *[…] until you're in a room together, you're the one doing all the thinking.* (Peter)

Implied in both of their comments is the fact that the work is compromised in some way when the patient is not there. They can feel that they are doing all the work, and although Natasha suggested that this can be useful to an extent, she highlighted the importance of 'transferring' the work – in other words, the next step is to think together *with* the patient. Sophie associated a sense of frustration and difficulty with this, feeling that the key task of psychoanalytic psychotherapy – bringing the unconscious into consciousness – can't be done without the patient in the room:

> *I think the task of bringing something that's delivered at a more unconscious level into consciousness, to a place where it can be thought about and then potentially worked with, but I suppose the frustration, and part of the difficulty with a DNA, is that the patient's not there.* (Sophie)

All the participants described a wish to encourage the patient back into the therapy room, as though the therapists were left holding the desire for contact and re-connection. I felt this further illustrated an experience of feeling left alone, or denied contact with the patient.

> *If someone weren't to come I might well phone them during the session to check, you know, are they coming in, so then there might be differences in that, if they pick up, if they don't pick up, if I were to then, you know, send them a message, sometimes I might […] phone, I might send a text* (Eleanor)

> *So my, my sort of, my approach would be to keep it short, the message, and try and get them in as soon as possible, you know to demand that they come in and um, regain the authority [slight laugh] if you like.* (Daniel)

> *[…] the point is to get them in, you know, you've gotta get them in and think about what's going on, erm, so, you know, what message can you send them to help them come in and think about why they're not coming?* (Peter)

The therapists described an effort to make contact with the patient in their absence, driven by a wish to encourage the young person back into the therapy room in order to think together about why they had missed their session. Eleanor described trying different forms of communication, which illustrates the extent of her wish to re-connect with the patient, while Daniel described his attempts as a 'demand', again highlighting how important it can feel to have the patient back in the room. Similarly, Peter emphasised the necessity ('the point is') of the patient being there so the work of understanding can be done together.

Finally, it is worth highlighting that all the participants made it clear that their response to a DNA – on an emotional and practical level – very much depends on the individual patient, and that they can experience a range of different responses:

> *I think it's, er, it's again case by case, they're so different, you know thinking about DNAs you can't make a generalisation, it so much depends on who DNAs, how they DNA, what happened in the week before, and the session before, is it something linked to what happened in the transference in the session, or is it something external* (Natasha)

> *I think for me it very much depends on the patient and what I think might be going on in the therapy […] I suppose there's all sorts of possible meanings, not a one-size-fits-all response obviously.* (Sophie)

> *[…] it's also different depending on each patient and how you are and your response with it, um, and at what stage of the treatment it's at* (Peter)

It seems that Natasha and Sophie both felt that their responses are particular to the individual patient, and that they consider these feelings to be related to the therapeutic relationship ('what happened in the transference') and the content of the therapy ('what I think might be going on in the therapy'). I will explore this further in the next section – 'Trying to make sense of absence' – but it is worth observing that the therapists' emotional responses were consistently linked to the context of the therapeutic relationship and significant meaning was attributed to this.

Trying to make sense of absence

Unconscious communication

It was clear that all the participants can consider DNAs to be a form of unconscious communication from the patient. As Sophie described:

> *I think with DNAs, more often than not, you're in the realm of an unconscious communication. Then I think as a therapist you're faced with the task first of all of, whether you like it or not, having to receive that communication, and then the struggle to think about what it is that might be being communicated.* (Sophie)

Here, Sophie shared her belief that an unexplained absence is often a communication of some kind from the patient. In her description of having no choice but to 'receive that communication' and then try to think about it, she touched on the way she first has a response and then uses this to try and understand what the patient might be communicating. All the participants referred to projection – that is, the process whereby a patient may attempt to rid himself of an unwanted or intolerable emotional experience by 'giving' that experience to the therapist instead (Bion, 1962), describing the way they consider their own feelings in response (their countertransference) as an indication of what the patient themselves might be feeling (a key aspect of psychoanalytic psychotherapy, as outlined previously in relation to Heimann's paper *On Counter-transference* (1950)):

[…] the DNAs were weaponised really, they were a tool to sort of prod me with, and to hurt me, and to leave me feeling as neglected as he felt, and as rubbished and underconfident and impotent, I think, in all this, as him. (Daniel)

I could really feel her distress and pain and really experience that, which I don't think would have happened in the same way if she was coming every week, erm, and wasn't DNA-ing […] [the fact] that I could feel that was incredibly important to the work. (Peter)

When speaking about specific patients they've worked with, Daniel and Peter's use of words such as 'weaponised', 'rubbished', 'distress' and 'pain' highlighted the intensity of the emotional experience they felt their patients were, in a sense, giving to them, even if unconsciously. Daniel's idea of it being a 'tool' and Peter's belief that it can be 'incredibly important' to the work suggests they both considered the DNAs to have an emotional function of some kind for the patient. They made evident the links they drew between their own emotional experience and that of the patient, demonstrating their effort to make sense of the DNAs in relation what was going on internally for the young person.

When discussing individual cases in more depth, all participants considered the connection between what they felt the young person was enacting in the relationship with them, and the patient's earliest experiences and relationships:

[…] she was a young person who'd been multiply sexually abused as a child and again I think that sustaining that kind of connection she was very, very ambivalent about (Eleanor)

> *[…] the DNA was, in her mind, just forgetting, and it was possible to think about where the sense of being dropped, which was something very particular of this case, whose mum […] was anorexic and there was a sense of being forgotten quite a lot, not being in her mum's mind* (Natasha)

> *I felt that there was a real fear that I would cut her off, that I would suddenly abandon her, and that she was also trying to bring about exactly what she most feared. Um and her mother had obviously left her, the adoptive mother had also* (Sophie)

Eleanor, Natasha and Sophie all considered their patients' early childhood relationships and reflected on the way these might have been mirrored in the way the young person related to them. Eleanor considered how complicated it might have been for her patient to sustain a level of intimacy or dependency, given her history of sexual abuse, whilst Natasha and Sophie wondered whether the dynamics in their patients' maternal relationships were being replicated with them as the therapist. Natasha wondered whether her patient was trying to show her, by 'forgetting' her sessions, what it feels like when you are not held in mind, while Sophie felt that her patient might unconsciously be trying to push her to respond in a certain way and 'bring about' the abandonment she feared (and had experienced earlier in her life). This suggests that the therapists were thinking about the DNAs in relation to the transference – as described earlier, observing the way the patient is relating to them, and reflecting on who they may unconsciously 'be' in the patient's inner world (Freud, 1905). Linked with this, as the participants observed that the unconscious, non-verbal aspect of DNAs could be an expression of a younger part of the patient rather than their more adult self:

I think as the work goes on you get more and more in touch, or they get more and more in touch with the younger them, and they act out in kind really. And actually, then you end up being with a sort of toddler in an adult body (Daniel)

But at that point, are you dealing with an 18-year-old, or are you dealing with a sort of a 5-year-old part of them (Peter)

[…] unconscious feelings [are] perhaps linked to the infantile conflicts being reworked, or sort of opened up. (Sophie)

These comments revealed the way the therapists can interpret the more non-verbal communication – or 'acting out' as Daniel put it – as perhaps coming from a younger, even infantile part of the young person. Peter and Daniel suggested there could be a contrast between the actual age of the patient and their emotional experience, while Daniel and Sophie both suggested that 'opening up' or 'getting in touch with' a more infantile self is part of the psychoanalytic process. It was evident that the therapists were holding in mind all the different aspects of the patient, thinking about the internal processes taking place which might not always correlate with the patient's actual age or appearance.

Participants also considered DNAs to have an attacking or destructive quality at times, sometimes feeling that the patient was doing something *to* them:

That particular case was, the DNAs were much more an aggressive attack of needing [me] to be worried um because she was also suicidal. So there was quite something aggressive and destructive that was going on in particular. (Natasha)

Often, they [DNAs] felt quite aggressive in many ways (Daniel)

Sophie felt that her patient's destructiveness was designed, albeit unconsciously, to test her capacity to emotionally withstand and survive her attacks:

[…] at the same time, I don't know, sort of provocatively testing the therapist's capacity to keep going. I suppose the patient I'm thinking of […] I really needed to kind of um be able to sort of survive her destructiveness (Sophie)

I think it probably was to do with the DNAs, because I survived something. Or we as the team survived something, something very unbearable. And I think that that was probably a first for him. Erm… in many ways. You know it goes back to the Oedipal thing and trying to kill me off. Actually, you didn't kill me off in the end and we were able to establish a relationship in the right position. (Daniel)

Sophie and Daniel both used quite violent language to describe what they felt their patient was doing ('destructiveness' and 'kill me off'). They illustrated their feelings of having survived some sort of attack from the patient, and attached an importance to their having done so ('I really needed to' and 'in the end we were able to establish a relationship in the right position'). I wondered about the degree of support and containment the therapists might have needed in order to manage these attacks without retaliation; indeed, they all referred at times to their need for support from colleagues and supervisors.

Controlling the boundaries

The participants shared thoughts and feelings in relation to the boundaries between themselves and the patient, though this took different forms. Eleanor and Peter considered their patients' absences as a response to the boundaries they had imposed within the therapeutic relationship:

> *I think something about the boundaries of the therapy that I was imposing being very difficult and somehow him [the patient] finding a way to take control.* (Eleanor)

> *Probably one of the most common things is, let's say, the cancellation or DNA that happens after a break or before a break, you know, especially working with this age group I found that, you know, before and after breaks there's more, you know, er, er, I would say a higher percentage of cancelled or DNA-ed sessions.* (Peter)

Eleanor reflected that it is her role as the therapist to create boundaries around the therapy, and considered her patient's absence as a communication that he was finding this difficult and responding with a desire to 'take control' of those boundaries. Peter thought about the breaks in therapy – again, a boundary imposed by him as the therapist. His observation that DNAs can often occur close to breaks implies that he feels they may be a response in some kind to the boundaries he sets around the amount of time he offers (or doesn't offer) to the patient.

Another, more emotional boundary that participants felt their patients were trying to cross was in relation to the therapist's mind. In one way or another, all the therapists described the way DNAs enable the patient to really get inside one's mind, with some feeling that this can be, on some level, the patient's intention:

Well, I mean, I suppose it's a way of, you know, being kept in mind (Eleanor)

The DNAs were really about a way to get in, inside me, in the sense of really needing to be in my mind and being worried. (Natasha)

I always thought DNAs were such a communication […] And um were sort of designed to sort of live inside you for the next week […] they know that they're a risky patient, and they know that I will worry, I think, if they don't turn up (Daniel)

Eleanor, Natasha and Daniel felt their patients were communicating a wish to be held in mind by their therapist, and using absence as a way to ensure this. As mentioned earlier, this might also suggest a doubt in some patients about the extent to which their therapist is holding them in mind when they're not in the room together. Natasha and Daniel wondered whether the patient actively makes their therapist worry about them as an unconscious attempt to secure a place in their mind, and all three participants above used language that suggested they feel the patient is actively trying to do something ('it's a way of', 'really about a way to get in', 'designed to'). Natasha's description of it being a way to 'get in' suggested she feels the boundary into her mind is being crossed in a somewhat intrusive way.

Daniel also reflected that his patient's absence was an attempt to manage the boundaries of the therapy in relation to closeness and distance:

You could never get the right contact. The temperature was also off, either too distant or too close. So that presented a different…actually he just cut off in the end, because

he couldn't bear the fact that I wouldn't love him back, in a way. And so he did DNA eventually, for good. (Daniel)

Daniel appeared to feel that his patient used his absence as a means to control the 'temperature' between them, which we could perhaps think of as the level of intimacy ('too distant or too close'). He refers to the patient's wish for greater intimacy, the word 'love' illustrating the intensity of desire he perceived in the patient, suggesting that the young person's 'cutting off' was perhaps a means to manage these intense feelings or to punish Daniel for not reciprocating them.

Avoiding dependency

Participants considered their patients' ambivalence towards dependency. Some linked this to the developmental stage of young adulthood; they considered the strive towards independence that comes with this period, and the resulting mixed feelings towards the more dependent state associated with therapy:

It was just too much to come three times a week, too much to manage the intensity and needing to regulate and be in control of how much she can need me or not. (Natasha)

[…] thinking about adolescents in particular, you might be wondering well is this a demonstration of the adolescent's independence, and an attempt to avoid the dependency that an attended session might represent for them. (Sophie)

> *But I think there's something about that sense of kind of wanting, you know, it being difficult to commit sometimes to the therapy, um, but still kind of wanting to keep that connection* (Eleanor)

Natasha, Sophie and Eleanor all reflect on their patients' mixed feelings towards dependency and need. Natasha observed the way her patient was perhaps using absence as a means to regulate how much she needed her therapist. Similarly, Sophie understood that young people might think that attending therapy is a sign of being dependent, and therefore could use absence to send a message to the therapist that they are independent. Eleanor suggested that a patient might feel caught between an avoidance of commitment and a desire for some sort of connection. She associated her patient's avoidance of dependency with a refusal to feed, feeling that her patient was actively turning away from the care or support she was offering:

> *He's talked, for example, about physically, even when he's starving, he doesn't eat, he just doesn't eat, so I think there's that kind of sense of um being unable kind of to access support or to, you know, to the self-care that he needs.* (Eleanor)

There was a suggestion here that she feels her patient might be actively depriving himself of the emotional nourishment of therapy, in the same way that he can deprive himself of food. Some of the therapists felt that when their patients turn away from help, this can indicate that they are particularly in need:

> *We came to understand DNAs were, took place very much when she was feeling very desperate and when it felt impossible for her to leave the house and come to her session, and it was a sign to me that actually she needed reaching out to* (Sophie)

> *I think another thing I've had quite often would be, you know there is that kind of thing of when they're feeling really bad, that's making a big generalisation, but that's the time when it's hardest to come in and when it's maybe the most important to come in.* (Eleanor)

These comments suggest that the therapists understood there was a conflict in their patient between needing help and being able to access help. Sophie and Eleanor commented on these conflicting feelings in the patient, and Sophie indicated that she and the patient reached this understanding over time ('we came to understand'). Similarly, Eleanor supported her interpretation by suggesting that it is something she has noticed 'quite often'.

The therapists evidently thought about what might be going on for their patient beneath the more surface level communication of a desire to stay away. Rather than drawing simple conclusions, all appeared to be holding in mind their patients' internal conflicts and mixed feelings. Peter held the view that a patient who struggles to attend might actually be a patient who really needs therapy. He considered their DNAs to be an indication that the patient finds it difficult to relate to others, and therefore could be something they need support with:

> *[…] if they're having such great difficulty in coming to something where the purpose of it […] is supposed to be helpful, then isn't there already a complicated relationship going on? And actually, shouldn't we be reaching out in some ways to those people? Or finding a way to try and work with them?* (Peter)

Peter is expressing a belief that if a patient has a complicated relationship with getting help, then this should be thought about and they should be helped with this. In saying 'shouldn't we be reaching out', he is perhaps suggesting that the onus is on the therapist or service to make an active effort to try and help the patient to attend, rather than simply perceiving their absence as a sign they are not interested or don't need help.

I also wondered about how difficult it might feel for the clinicians to receive the communication from their patient that they are not needed, or that what they are offering is of no use. This must be a challenging feeling to sit with for someone whose professional role centres around helping others; on some level, perhaps their interpretations also served as reassurance to themselves that they are of value to the patient.

The value of DNAs

DNAs can be ordinary and important

In different ways, participants emphasised how DNAs can play an ordinary and important role in treatment. One way this was communicated was through the acknowledgement of projection as an ordinary and developmentally-appropriate aspect of adolescent communication:

> *I'm very much thinking about the adolescent process, and the turmoil and confusion of that, and the tendency of adolescents to project their feelings* (Sophie)

> *We are working with adolescents after all! [exclaimed]. There's something quite normal about DNAs as well.* (Daniel)

Sophie referred to the 'adolescent process' and expressed a belief that it is ordinary for this age group to communicate through projection. (As explored earlier, all participants felt that DNAs could be a means for the patient to project their own emotional experience onto the therapist.) Daniel exclaimed that 'we are working with adolescents after all', as though it is normal, and even obvious, that one should expect this sort of behaviour and acting out when working with this age group.

Further to this, a common thought amongst the participants was that a period of non-verbal acting out and projection can be an important stage of the treatment:

> *I think it was incredibly important… so I think, without those DNAs, I wouldn't have had a real experience of being terrified that she was going to die. You know, and I think that I really needed to, in a very real sense, really experience the fear that she was going to die and kill herself […]* (Peter)

> *So they were a real part of the treatment, you know, a real live part of the treatment. Until he was able to come in and tell me he hated me, which of course is a development to just not turning up. I mean that was the bit of work, that was the drive to a healthier state of mind, to be able to come in and not DNA. That's the case in a nutshell.* (Daniel)

> *I felt it wasn't until I had really had the experience that something started to change, and it also started to change in me […] I mean, I think there were stages, I think that's what I'm trying to say.* (Sophie)

The participants appeared to want to advocate strongly for the important function that DNAs had played in therapy with particular patients. Peter and Sophie explained that it had been necessary for them, as therapists, to have a particular emotional experience first, in order for it to be subsequently understood with the patient. They emphasised the extent and realness of this emotional experience ('it wasn't until I had really had the experience', 'I really needed to, in a very real sense, really experience'), and suggested that their patient made progress *because* of this initial period of projection and unconscious communication ('without those DNAs, I wouldn't have had…' and 'It wasn't until […] that something started to change'). Daniel expressed a similar conviction in the value of his patient's DNAs, emphasising that the period of non-attendance was very much a 'live part' of the treatment. He believed that the patient's shift from not attending to being able to come in and express himself verbally was 'the case in a nutshell' – in other words, that *was* the work.

Both Sophie and Daniel referred to needing to survive something in the therapy, as though it was their capacity to withstand the young person's acting out and painful projections that had ultimately led to progress:

> *I think it enabled her to trust in our relationship which […] I hope that it enabled her to develop a sort of internal link to a good object. […] But something about because I had been able to survive her abuse, or her rejection, her wastefulness, wasteful acts, her testing.* (Sophie)

> *I think it [the patient's progress] probably was to do with the DNAs, because I survived something. Or we as the team survived something, something very unbearable. And I think that that was probably a first for him. Erm in many ways. You know it goes back*

to the Oedipal thing and trying to kill me off. Actually, you didn't kill me off in the end and we were able to establish a relationship in the right position. (Daniel)

Sophie and Daniel attributed their patient's development in therapy to having experienced a therapist who could withstand and survive the young person's unconscious attempts to reject, abuse, or even 'kill off' their therapist. Sophie felt she was being tested by her patient; showing she could survive these tests enabled her patient to trust her, and to develop an internal link to a good object. Daniel felt his patient's failure to 'kill him off' enabled their relationship to shift into the 'right position' – a phrase which suggests a place of progress or development.

It was emphasised, however, that DNAs are only helpful when there *is* the opportunity for the therapist and patient to come back together to think about the non-attendance, and start to understand the meaning:

Interviewer: You mentioned thinking about it with the patient if or when they do come back – can you say more about that?
Peter: Absolutely, that's absolutely vital. I just think it's so important, and especially, er, with this age group.

[…] if you don't see them how do you, you know transfer the work? I think there is a reality of things that, er, yes DNAs can be thought about and worked with and communicated, but up to a certain point. I think there is a limit to also our sense of omnipotence and thinking that our thinking will do the work for them […] you can't do it through your own thinking alone. (Natasha)

Both Peter and Natasha highlighted that the work of understanding the patient's absence ultimately needs to be done together with the young person. Natasha suggested that although the therapist can, to an extent, do some thinking on their own to try to understand the meaning of the DNA, this does then need to be 'transferred' into thinking with the patient. She suggested that it is omnipotent of the therapist to believe it is their thinking alone that helps the patient, and, like Peter, she feels that the work must be a joint effort if progress is to be made.

Making a case

Daniel, Sophie and Peter emphasised numerous times throughout their interviews that they considered DNAs to be an important part of the treatment, which made me wonder whether they had a motivation to make a case for this. This impression was supported as they went on to describe the way they have had to advocate in their respective clinics for the importance of 'holding on' to patients who are not attending, needing to make a case for working therapeutically with DNAs and not discharging patients too quickly:

> *And there was a real push pull from the service about are we gonna keep him or are we gonna let him go? And I was very firm, er, in trying to keep him because I thought we needed to work through whatever it was. And, luckily, I had a supervisor that was supportive of that. As a whole the service were not keen on him missing 6 or 7 in a row sometimes. But they also understood because the service say oh it was a communication that needed to be got hold of, which it did in the end.* (Daniel)

> *I think it's been a challenge for us in the service to really keep kind of making the argument about the importance of DNAs for this particular age group and the need,*

the way we would really expect, as we spoke about earlier, adolescents at times, or certain adolescents to, or DNAs to be an important part of the work. (Sophie)

I was given enough license to think this is a part of the treatment, er, this is important and actually she is, it's not that she's disengaged, in fact she's very engaged in the treatment, but this <u>is</u> the treatment, or this <u>is</u> the relationship […] and I was given the opportunity to do that despite there being long waiting lists (Peter) (underlined words indicate emphasis in speech)

It seemed that the participants were describing a tension, or a 'push pull', within their services between tolerating DNAs as an ordinary and important part of psychotherapy with this age group, and discharging patients due to long waiting lists. Daniel described a need to be firm, Sophie referred to 'making the argument' and Peter noted how he was 'given enough license' – all of which suggested a desire in the participants to stand up for the importance of allowing space for young people to DNA in therapy. Peter strongly emphasised that the period of non-attendance was very much part of the treatment, which perhaps reflected his need to emphasise this in other professional contexts. I wondered whether this wish to persevere with treatment might also reflect a difficulty for the therapists to close cases, perhaps due to a feeling that they are admitting defeat, or have failed in some way, and whether they might hold onto cases in order to avoid these difficult feelings.

While Natasha did not so readily advocate for the importance of DNAs in therapy, she did share her observation of DNAs feeling 'political' within CAMHS:

> *The reality is when I was working in CAMHS here, if they were not coming 15 minutes into the session you would call them, and then this is entered as 'attended' because you had a 5-minute conversation, so I think there is this going on a lot because DNAs are bad for, the reports and things like this. I think it's also political. And you try to protect the therapy in a way sometimes and you don't want to put it down as a DNA.* (Natasha)

She speculated whether therapists stretch the truth when they record the outcome of an appointment, stemming from a wish to protect the therapy and to avoid a case of non-attendance making a service look 'bad' on reports. From this, and from Daniel, Sophie and Peter's comments above, we might infer a sense of pressure from the organisation or wider system that DNAs are not to be tolerated when there are other patients waiting – something which the participants find themselves having to speak up against, or protect their work from.

Facing reality

There's a limit

All the participants were clear that while it is important to try to work with and understand DNAs, there is a limit to how long you can allow a young person to miss sessions. Peter spoke about the reality of time limits, both in therapy and also in life, and how this must be faced by the therapist and the patient:

> *What I'm advocating, I suppose, is that it's something that should be struggled with, but not endlessly though, you know, there is, time is a very helpful aspect of all therapy.* (Peter)

He brought up the myth of Sisyphus in his interview, linked with an association his patient had to a dream. He described her progress from a sense of endless trudging into something more developmental, which I felt illustrated a common wish amongst the participants to avoid DNAs becoming endless, and their wish to help the patient shift from using absence as an unconscious communication into the realm of something that can be spoken about and moved on from.

Sophie and Natasha also spoke about the helpfulness of limits, particularly in relation to helping the young person to take some responsibility for their treatment:

> *I think there was something about my acknowledgment of my limitations that was important for her and enabled her then to feel that she could take some more responsibility, um, and things really shifted at that point […] she pretty much came consistently for the duration of her treatment.* (Sophie)

> *[…] it was needed to [say] ok, that's it, we can't, this is it, er, and actually she has come, well, for now 3 sessions in a row on time and erm seems to be very kind of committed in a way, and I wonder whether there was something about saying that's enough* (Natasha)

Sophie and Natasha noticed that setting limits had led to improved engagement. Sophie suggested that it helped the young person to take some responsibility for her own attendance; this made me wonder whether enforcing boundaries had encouraged the patient the be in touch with her own desire to attend therapy, rather than projecting all the desire for contact onto the

therapist. Natasha took a noticeably 'no-nonsense' approach to DNAs, making clear her stance that she does not tolerate frequent non-attendance:

> *I think they do need the space to act out, but not endlessly. You need to see where they're actually whether they can take in something. If you DNA for a year you see them, I mean, you see them ten times in a year, I don't think you're doing psychotherapy.* (Natasha)

Her view is that the treatment is no longer psychotherapy if the patient is frequently missing sessions, which links to her earlier comment about it being omnipotent for the therapist to think they can do all the work on their own. Peter, on the other hand, spoke about how difficult it can feel for him personally to reinforce boundaries and end treatment:

> *Erm so there've been times when I've held onto things in an unhelpful way as well, erm, and that's partly maybe my own capacity that I have to look at and struggle with, erm, and you know cos I, you know, I hate closing cases without trying to work through something like that.* (Peter)

He acknowledged that it can be actively unhelpful to 'hold onto' cases. It seemed he might be suggesting that his own feelings around boundaries and endings can get in the way, perhaps obscuring his judgement at times about whether it is in the patient's best interests to continue with therapy. Sophie and Natasha both spoke about the need to accept that a DNA might actually be a sign the patient is not ready for psychotherapy and therefore not able to engage in a helpful way.

Being realistic

As well as the therapeutic helpfulness of setting limits, all the participants made clear their awareness of the limited resources in their charity-funded or NHS services and the need to be realistic about this:

> *I mean, I will talk to a young adult about our waiting lists and about the fact that, you know, if you're not able to take up the space, we have limited resources and we would need to be thinking about, you know, um, not continuing to offer a service if they're not able to take it up.* (Eleanor)

> *[…] if you do not come to your next session and I do not hear from you then, you know, we will unfortunately not be able to give you a space, you know, keep a space for you.* (Peter)

Eleanor described the need to be frank with the young person about limited resources and waiting lists. Peter's use of the word 'you', as though in dialogue with the patient, suggested he would speak directly with the young person about this too. This feeling was expressed amongst all participants, in addition to what felt like a more implicit pressure to fill the space with another patient. It felt at times that there were two patients in conflict in the therapist's mind: the patient they are currently seeing, and the waiting patient that could fill the unattended slot. Sophie felt that this pressure had increased throughout the years she's been working in her service, as resources have become scarcer:

I think the pressures to discharge patients and the pressure not to tolerate DNAs have really increased over the years, you know, understandably in a way in relation to scarce resources. (Sophie)

Some participants also acknowledged that, in addition to service pressures, there are also demands on young adults today which can affect their ability to attend or commit to therapy:

I think social media and sleep deprivation is quite a big thing, because I think a lot of the young people I'm working with a lot I would say are on devices and are not kind of going to sleep until 3, 4 in the morning […] and then I think it's also a stage where they might be doing you know starting jobs or at uni or doing masters or kind of doing work experience so kind of how to find that balance between how you prioritise. (Eleanor)

I mean look, I know we like to think about, just focus on the internal world a lot but I think in this day and age […] you have to look at external factors as well, and what's going on for kids, why are they DNA-ing, what are the pressures at home, who are they looking after, and why they can't cancel or you know, stuff like that which is important to hold in mind as well. It's not all internal communication all the time. There are other factors at work as well, that you need to be mindful and, erm, sympathetic to. (Daniel)

Here, Eleanor and Daniel demonstrated how they think about what is going on for young people at this age, and the external pressures that might need to be considered when trying to understand a patient's struggle to attend. Eleanor thinks more about societal and developmental factors affecting young people, such as social media and looking for jobs, while Daniel refers to particular difficulties that might be affecting an individual externally, such as pressures at

home. He highlighted the need to hold onto both internal *and* external factors ('it's not all internal communication').

Striking a balance

This subtheme encapsulates the extent to which all the participants seemed to be negotiating certain dilemmas in their work with young adults who DNA, often referring to the need to find a balance between conflicting demands, priorities or different ways of viewing things. Some referred to the official policy in their services, and the contrast between this and what happens in reality:

> *I disagree with the [service's] idea of you know DNA twice and then you're out, because I think they do need the space to act out, but not endlessly.* (Natasha)

> *Well I think there is an official trust policy, which I believe is if there are three consecutive DNAs, I think the idea is that the patient should be discharged. In our service we work in a rather more flexible way in relation to that.* (Sophie)

> *Sometimes, erm, I have held onto cases longer, erm, than let's say our work policy would normally allow* (Peter)

Although the official policy around DNAs differs between their respective services, the participants seemed to be expressing a need to find a middle ground between that policy (for example, 'DNA twice and then you're out') and endlessly tolerating DNAs. Natasha shared her belief in the importance of young adults being able to act out to a certain extent, while

Sophie agreed that a degree of flexibility is needed when working therapeutically with this age group. Linked to this, participants considered it important to make decisions on a case by case basis, rather than simply adhering to a fixed formula or policy:

> *I think that balance to know how to manage and each case is different* (Natasha)

> *I try to as best as I can […] I try to do it absolutely on a case by case [basis] […] depending on the situation, depending on the young person* (Peter)

The participants went on to describe other dilemmas in their work, communicating a need to hold onto conflicting thoughts and feelings in their minds, and questions that are perhaps not easy to find the answers to:

> *[…] do you stay and take in the worry and just try to contain it because they need this, or do you act and do something?* (Natasha)

> *I felt it was very important that I could withstand and accept in a way her non-attendance, but at the same time it felt I suppose the tension was that I was also then colluding with her destructiveness and something that was very wasteful, but yet if I didn't do that it felt as if I would be really sort of retaliating and not receiving what felt like a very important communication of distress.* (Sophie)

> *Eventually I had to say look, you know, if you don't come and…then I'm going to have to, I can't keep you a space. And he contacted after that which, again, sort of the day*

after I'd put the boundary in which made it incredibly difficult, er, but I offered him a goodbye session (Peter)

Natasha, Sophie and Peter made it clear that working with adolescents and young adults who DNA is not straightforward, and that there are not always easy answers. Natasha described a conflict, when a risky patient hasn't turned up, between containing her anxiety about the patient's wellbeing and acting on this worry in a more practical way. Sophie shares a dilemma about the need to withstand and receive her patient's unconscious attacks on her and the therapy, whilst holding in mind that her tolerance could potentially be experienced as her 'colluding' with the patient's 'destructiveness'. Peter shared how difficult a dilemma it can feel to close a case, illustrating the fine line therapists may have to tread when it comes to reinforcing boundaries (his patient got in touch the day after Peter said he would have to end treatment). This illustrates the extent of conflicting feelings, ambiguity and nuance when it comes to working with young adults who DNA, including the struggle between balancing the needs of the patient and the needs of the service, and the importance of making decisions on a case-by-case basis.

DISCUSSION

In this chapter, I will discuss my findings in more depth, and consider them within the context of the wider research outlined in my literature review.

An emotional response

All the therapists made it clear that when a patient unexpectedly does not turn up for a session, this can have a profound emotional impact on them. They were open about the feelings that can be stirred up, and the way their responses to a patient's unexplained absence can vary hugely, ranging from rejection to relief. Their feelings depend on the individual patient, the stage they are at in therapy, and what they feel the young person might be trying to communicate with their absence.

As I described in my literature review, psychoanalytic psychotherapists use these emotional responses (their countertransference) as a tool for understanding their patients' unconscious communication (Heimann, 1950), and I will explore this in more detail in the next section. However, it feels important to first consider the therapists' feelings as a personal experience, to help us understand what it is like on an individual and human level when one is left waiting for a patient who doesn't arrive. The therapists spoke about feeling rejected, neglected, inadequate, forgotten about, dropped from the patient's mind and even not considered as an actual person – painful feelings which were described as hard to deal with in the moment (before having the chance to reflect on them, often with the support of colleagues). Participants were clear that there is a marked difference between a patient getting in touch to cancel (and therefore the therapist having some idea of what is happening) and a patient simply not showing

up. The latter leaves the therapist in a state of not knowing, evoking all sorts of fantasies and anxieties.

These anxieties associated with not knowing featured in different ways in the interviews. Therapists spoke about finding it hard to get on with other things during the session time, preoccupied by fantasies about what might have happened to the patient and feeling left 'in the dark'. They can wonder whether they got things wrong with the patient in the previous session, questioning whether they are a good enough therapist, and can feel humiliated in front of colleagues about their perceived failure to 'get hold of' a patient.

This sense of self-doubt evoked by feelings of uncertainty, and the anxiety in response to sitting with the unknown, was mirrored, I felt, in the way the participants approached the interviews. One arrived extremely well-prepared, seeming to have memorised the questions I was going to ask. Three of the participants were self-deprecating about their performance in the interview, apologising for being unprepared and criticising themselves at the end for having not made sense or having not said enough. One participant even 'DNA-ed' the interview, forgetting the date and time that we had arranged, meaning that we had to plan an alternative slot. There are many ways to think about these different characteristics, but it did make me wonder whether there was something about the experience of thinking about DNAs that put the therapists in touch with the associated state of uncertainty, leading them to perhaps manage the resulting anxiety in different ways.

I had the impression that it was difficult at times for some participants to speak about how it feels when a patient doesn't turn up. I noticed how some avoided saying 'I' (which could imply ownership of their feelings), and instead referred to how 'you' feel 'as the therapist'. This had

the effect of distancing themselves from their emotional experience, and perhaps suggests how acute some of the more painful feelings can be, of not being good enough, or being rejected for example. Does it feel comforting to assume that all psychotherapists are having the same experience, rather than contemplating one's isolation with these difficult feelings? It also made me think about the participants' knowledge that I work in the same clinical discipline as they do; at times I had the feeling that some were trying to pull me into the experience with them, repeating phrases such as 'you know', as though telling me, quite literally, that *I* know what it feels like too. Sometimes I had to encourage them to expand on what they were saying, and wondered whether they assumed that I would fill in the gaps myself, in the belief that the experience they were describing was one that I shared.

Perhaps this wish to be joined in the experience also reflected the sense of aloneness that the absent patient leaves their therapist with. Participants conveyed feeling alone in a relationship where there should be two, left to do all the work and denied the opportunity to think together with the patient. It was suggested that there is a limit to how much thinking one can do by oneself, and that the process of psychoanalytic psychotherapy – that is, to bring the unconscious into consciousness – cannot be achieved without the patient in the room.

All the therapists emphasised the need to encourage the patient to re-engage, in order to begin the work of understanding their absence from therapy. They described the different ways they might try to make contact with the patient – phoning, texting, emailing – efforts perhaps driven by their own discomfort around feelings of aloneness and uncertainty, as well as by the importance they place on the patient's physical presence in the therapeutic relationship. It seemed the therapists felt left to hold a lot, emotionally, in the patients' absence. This included the desire for contact (a desire which might feel intolerable at times for the patient to be in

touch with), among other difficult feelings – for example, one therapist described being left carrying intense worry and anxiety while the patient appeared sufficiently relieved of these feelings to be able to go and enjoy a holiday.

As I will come to later, the clinicians considered their patients' difficulty trusting that they are held in mind by their therapist. I wondered whether therapists also carry that doubt – do their patients remember *them* during the week? – leading the therapist to want to reach out and make contact, and finding it hard when patients send rather impersonal messages to the service, refusing to acknowledge their therapist as a human being by naming them or addressing messages to them. Linked to this, I was curious to note that clinicians hardly mentioned the possibility that the patient might not wish to be in therapy at all, or might not find it helpful. It feels worth considering the therapists' own conscious and unconscious motivations behind their choice of profession, and whether the patient's rejection of their offer of help might be experienced as a sort of narcissistic injury (Kohut, 1972). Can a therapist feel like a therapist when there isn't a patient in the room?

This somewhat anxious desire to reach out and reconnect with the absent patient was also linked with the profound concern aroused in the therapist when a patient at risk of self-harm or suicide does not turn up for a session, and how difficult it can be to know how to manage this. In these circumstances, the worry about the patient's wellbeing can be all-consuming, with therapists anxious about whether their patient is even still alive. I had the impression that this experience could be deeply disturbing for the clinicians, and picked up on a sense of powerlessness in these moments. One clinician described being left thinking 'what is happening?' while another illustrated the fantasies his mind travels towards ('have they killed themselves?') in the absence of knowing what is going on. It occurred to me that the therapists

felt somehow at the mercy of the patient in these moments, forced into a state of powerlessness and uncertainty. I wondered about the extent to which this 'power' over their therapist might reflect the patient's unconscious attempt to master their own vulnerability (a vulnerability represented, in their mind, by the therapist).

I was curious in the interviews about the link between absence and death. In addition to the fear that the absence of a suicidal patient might indicate that they have actually died, some clinicians interpreted absence as a more symbolic attempt to destroy or 'kill off' the relationship with their therapist, not allowing the emotional connection to stay alive in their mind. One participant asked rhetorically 'has the therapist died [in the patient's mind] at that point?', while another associated his male patient's absence with infantile phantasies of killing off his father as an Oedipal rival.

This theme of death could perhaps also symbolise separation and loss. One participant associated missed sessions with an avoidance of separation and endings , or the reality of time passing. An ending and separation occurs after each 50-minute therapy session, not to mention the fact that each therapy session brings the patient closer to the end of treatment – realities which may be unconsciously experienced as a painful reminder of the losses and separations involved in the transition into adulthood. Missing a session could signify a young person's attempt to deny, or avoid being in touch with, these unwanted facts of life. Instead, the 'distress' and 'despair' must be felt by the therapists, as they sit in the room wondering where their patient is.

Interestingly, this avoidance of endings was echoed in the interviews; I noticed the therapists reacted to me ending the interview by suddenly thinking of many more things to say, filling

the space and making it hard for me to draw the interview to a close. I wondered if there was something about the subject matter which led them to unconsciously postpone the ending of *our* time together.

I was curious about the feelings that therapists might not have spoken about so freely, such as relief or anger, perhaps because they are more difficult or shameful to talk about. For example, in Anderson's study (2015) participants shared feelings of relief in relation to patients not attending, particularly when it gives them free time to get on with other work. Only one participant spoke directly about feeling relieved in response to his patient's absence – in his case, it helped to cool the intensity of the therapy – while another explicitly described her frustration at having wasted her time and energy to get to the clinic only to find her patient didn't turn up. Other participants conveyed their frustration more implicitly, with an irritated tone of voice or despairing hand gestures. I wondered whether the clinicians might have found it harder to share certain emotional responses for fear that it might make them appear uncaring or cross a professional boundary.

Given the NHS funding crisis and its associated pressures on services, it is highly likely that some relief may be felt on a practical level, too, when a patient DNAs, as space is freed up in the clinician's busy schedule, providing much-needed time for administrative tasks. It's interesting to consider the interplay between external realities and internal meaning making when it comes to therapists' responses. It is hard, for example, to disentangle the 'practical' relief at having more free time in the day, from the meaning of this relief in relation to the patient. For example, might there be something occurring on an unconscious level in the therapy which the clinician is finding difficult to bear, and which might therefore mean she is rather relieved at the opportunity to avoid the session that week?

Trying to make sense of absence

The participants all spoke about the contrast between a cancellation and a DNA, with some explaining that while a cancellation is a more conscious message to the therapist, a DNA feels very much in the realm of unconscious communication. It was noticeable the extent to which all participants paid attention to their own emotional responses, or their countertransference, as an insight into what their patient might be trying to communicate to them through their absence. In line with Hennissen et al.'s study (2020), participants felt that their countertransference helped them understand what sort of figure, or 'object', they might be in the patient's mind at that point in the therapy. For example, one participant felt that her own feelings of being a useless therapist suggested that her patient was currently perceiving her as a cruel and neglectful maternal object.

The concept of projection – that is, when a patient tries to rid himself of unwanted or intolerable feelings by projecting them into the other (Bion, 1962) – was raised frequently by the participants. Participants reflected on their patient's wish to communicate how they themselves feel. For example, one clinician wondered whether his feeling 'neglected, rubbish and underconfident' in response to his patient's absence was in fact a projection of the young person's own intolerable emotional experience. Similarly, when working with patients at risk of suicide or self-harm, therapists felt that their own levels of distress and anxiety were an indication of the state of mind of the patient. They suggested that in the early stages of therapy, this sort of projection might be the only means of communication the patient feels capable of, just as Casement (1985) considered unexplained absences as a communication of feelings which the patient may not yet feel able to put into words.

When thinking about DNAs, the clinicians considered their patients' histories, drawing links between their earliest object relations and the dynamics which they felt were being enacted in the therapeutic relationship, or the transference. This significance of early experience and relationships align with the findings of Leavey et al. (2011), who found that early traumatic experiences were linked to patients' difficulty attending therapy and trusting their therapist. In this present study, one clinician spoke about her patient's childhood experience of not feeling held in mind by her mother, and her unconscious wish, by 'forgetting' her session, to give her therapist an experience of not being held in mind by her. Another reflected on her patient's fear that her therapist would abandon her, just as her own mother had done when she was younger; her DNAs were considered as a means to 'test' her therapist and push her to give up on or 'abandon' the patient. This reflects Freud's theory of the compulsion to repeat certain patterns of relating as a means to work through past experiences (1914). One therapist considered one young adult patient's experience of childhood sexual abuse, which had led to a strong ambivalence towards emotional intimacy in the relationship with her therapist. For this young woman, missing sessions functioned as a way to regulate this intimacy.

In further accordance with Leavey et al. (2011), and also Binder et al. (2008), some participants observed that patient absence did not necessarily equate to not needing help. On the contrary: it was believed that the struggle to turn up to a therapy session was often a sign of the patient being in a particularly difficult place and consequently depriving themselves of the help they need. One participant observed that if a young person is finding it so hard to communicate in an ordinary way, and is resorting to not showing up rather than letting the therapist know what's happening, then this could be a very good indicator that they might actually be in need of therapy to help them understand these interpersonal difficulties.

Participants all highlighted the mixed feelings that young adults can have towards dependency and parental boundaries, which is supported by existing literature (Syed & Seiffge-Krenke, 2013; Catty, 2021). Participants noticed the way DNAs can occur in response to the therapist's own holiday break, reflecting on this as a means for the patient to take back control of the boundaries, or to defend against their own dependency. In other words, the boundaries imposed by the therapist, and the patient's inability to control the therapist's comings and goings, may serve as a reminder to the patient of their (at times, intolerable) dependency on their therapist. In turn, they may exercise control over their *own* comings and goings, perhaps in retaliation or as a defence against the helplessness associated with dependency. Therapists considered missed sessions as the patient's attempt to regulate this dependency, as well as a form of self-inflicted deprivation as an attack on the dependent part of the self.

Also mentioned was the patient's omnipotent attempt to control the boundaries, enacted by pulling the clinician out of the therapeutic frame. In the patient's physical absence, the therapist is forced to helplessly 'chase up' the young person by making contact outside the therapy room via email or phone. Reflecting on the therapists' feelings of powerlessness and rejection, I wondered whether DNAs can ignite a sort of battle for control in the therapy, whereby feelings of helplessness are unconsciously passed between therapist and patient. In turn, perhaps this conflict can play out in the form of tensions between the therapist and their organisation, with the therapist feeling powerless in the face of strict policies. Participants described a wish to assert their *own* independence/autonomy over their therapeutic work, with one therapist reflecting on the freedoms afforded to him as a more qualified ('adult') therapist compared to when he was a more junior ('adolescent') clinician. Perhaps there is something felt to be intolerable for therapists about their own dependency on the 'parent' organisation and its boundaries and limitations. Multi-disciplinary team (MDT) meetings, with representation from

different disciplines and service management, may be a space in which this battle between the desire for autonomy over one's work and the need to 'follow the rules' of the organisation get negotiated. I wonder how CAPTs get positioned in these MDT meetings; is their wish to allow time for adolescents to act out and to understand the deeper meaning behind missed sessions viewed by colleagues of other disciplines as indulgent? Or is their wish to engage with some of the more uncomfortable, perhaps even unbearable, uncertainties and ambiguities of therapeutic work something which other colleagues defend against by imposing more rigid structures or policies?

I noticed that at times participants used somewhat violent language to describe what they felt their patients were doing *to* them by missing a session without explanation. DNAs could be experienced as a destructive attack on the treatment and on the therapeutic relationship, as well as an 'aggressive' attempt to get inside the therapist's mind. This was considered in relation to the patient's difficulty trusting that they could otherwise be held in mind by their therapist, and there was a common feeling of powerlessness in the face of this intrusion. One described the way a DNA 'lives inside you for the week', and it was suggested that this can be the patient's intention, even if unconscious. Therapists also observed how discussion about absent patients can 'intrude' on team meetings, taking up a lot of space. Furthermore, participants spoke about the significance of surviving these attacks from the patient, considering their ability to withstand the patient's aggression to be an essential part of the progress in therapy (a more symbolic representation, perhaps, of psychoanalytic work with younger children where *actual,* more physical attacks on the therapy and therapist might need to be survived (Rustin, 2001)).

It was made clear that while it is important to think about the patient's internal world, and what they might unconsciously be communicating through their absence, the external pressures on

young adults are great. Participants were realistic about considering whether a patient is ready for psychotherapy, and also sympathetic to factors such as social media and sleep deprivation, starting university or beginning jobs, and other pressures at home such as caring duties – all of which might also explain why a young person might find it hard to attend, or to remember, their therapy session. This is supported by Philips et al. (2006) who suggested that young adults may have a particular focus on the external world and the situations they find themselves in, and the way this needs to be handled carefully by the therapist. That said, perhaps the internal and external worlds cannot be so easily distinguished from one another. Social media use, for example, is of course an ordinary part of modern reality. However, we may be curious about *why* a young person stays up all night using their phone prior to their therapy session the following day. Could this also be interpreted as a destructive attack on themselves or their therapy, a sign of addictive processes or indeed a psychic retreat in one's mind *away* from external reality?

The value of DNAs

At times, I felt as though the participants were trying to make a persuasive case to me, the interviewer. They reiterated and emphasised, verbally and through body language, their feeling that DNAs are an important part of psychoanalytic treatment with this age group, even going so far as to clarify that with some patients, progress was made precisely *because* they were allowed to act out through a period of missed sessions. Their apparent wish to justify the significance of DNAs in therapeutic work suggested that there is an opposing belief or pressure coming from somewhere – perhaps the organisation or wider system. Participants referred to official policies introduced in their services to manage DNA rates – for example, after two consecutive DNAs the patient should be discharged – which illustrates a wish to 'clamp down'

on DNAs within the organisation. There was a consensus that these policies are too limiting, leading clinicians to consistently have to make a case within the service as to why they wish to persevere with a young person's treatment. I heard in their words a plea for the wider organisation to recognise that DNAs can be part of the process of psychoanalytic psychotherapy.

One participant even described it as 'political', explaining that DNAs can reflect badly on the service, and, as such, clinicians sometimes try to disguise these on reports in order to protect the therapy. She told me that her service gets paid for a session that is attended or cancelled but receives no money for a DNA-ed session, reflecting in no uncertain terms the lack of value the organisation assigns to a missed session. Others expressed gratitude towards their service/management for giving them 'license' to persevere with work with patients who weren't attending, despite long waiting lists.

Why are DNAs important? The participants shared the view that these missed sessions can be an ordinary form of acting out amongst this age group, speaking about projection as a developmentally-appropriate form of communication. They referred to adolescent processes; although talking about work with older adolescents and young adults, it is believed that these processes continue to be reworked into early adulthood for many young people. Despite the difficult feelings that these unexplained absences can stir up, none of the therapists gave the impression that DNAs are unusual. Three of the participants strongly believed that tolerating a period of DNAs in the work with certain patients actually contributed to progress in the therapy. They spoke about 'stages' – that is, their belief that unconscious communication and acting out are necessary in order for this communication to then be brought into consciousness with the patient and understood. This approach fits the theory which underpins psychoanalytic thinking

– that is, that our behaviour is driven by factors beyond our conscious awareness (Lemma, 2016). Clinicians gave examples of cases with whom they felt progress would not have been made, had the patient not had the opportunity first to project their feelings in an unconscious way and to 'give' the therapist an experience of something, before this experience could be verbalised. They spoke about their capacity to withstand the patient's projections and attacks as enabling the patient, over time, to develop a secure relationship with the therapist and, subsequently, a good internal object. This links with Binder et al.'s finding (2008) that ruptures in the therapeutic alliance, such as missed sessions, can ultimately provide a helpful opportunity to repair the rupture, leading to positive developments in the therapeutic relationship.

This present study could perhaps be seen to contradict research which shows that non-attendance in therapy has a negative impact on recovery for adults (Killaspy et al., 2000); that involvement in therapy is the most important determinant of outcome for adolescents (for example, Shirk & Karver, 2006); and that no-shows have a negative impact on the scale and rate of symptom change (Xiao et al., 2017). However, these studies do not necessarily oppose the findings of this project. Instead, this project perhaps sits alongside these more quantitative findings and contributes a deeper layer of understanding behind non-attendance. Based on my own findings, I would suggest that there could be a broader definition of 'involvement' or 'engagement' with therapy that goes beyond the act of a patient physically attending a session. Interviews with participants in this present study suggest that, as one therapist described, 'a missed session is still a session'. In other words, the therapy can still be taking place, and the young person can still be engaged with treatment, even if on the surface it appears that they have disengaged. Non-attendance can be a powerful form of communication and, as already mentioned, can initially be the only means of communication a young person feels able to

employ. The fact they are communicating in this way to their therapist could be an indication that something is happening between patient and therapist, albeit non-verbal. As one clinician described, the period of non-attendance with his patient was very much a 'live' part of the treatment. Xiao et al. (2017) were careful to point out that non-attendance has a greater negative impact when it happens at the very beginning of therapy, rather than as part of ongoing treatment in which the patient has already engaged. Furthermore, two of the studies mentioned above were conducted with adults, and therefore don't consider the contributing developmental dynamics (such as acting out ambivalence in relation to dependency), whilst Shirk & Karver's study (2006) looked at Cognitive Behavioural Therapy, in which attendance at sessions may carry different significance or meaning.

Clinicians did highlight that DNAs are only helpful when they can be thought about together with the patient. Examples were given of cases that had to be closed because there was not sufficient opportunity to work through, contain and understand what was happening with the patient, and therefore allowing the young person to continue to miss sessions was considered unhelpful and potentially risky. It was felt that although the therapist can do a certain amount of helpful thinking by themselves, understanding the meaning behind non-attendance is a dual process in which the patient ultimately does need to participate. It seemed that it was difficult to assess whether to close a case, and participants reiterated the importance of making a decision based on the individual patient and with the support of the clinical team.

Facing reality

Despite the limiting nature of official policies around DNAs (as described above), all the therapists agreed that there must be boundaries around the extent to which no-shows can be

tolerated. The reasons for this seemed to be twofold. On a wider service level, there was a shared acknowledgement and respect for long waiting lists and financial pressures on public services, as evidenced by Baraitser & Brook (2021). None of the participants believed that therapists should tolerate DNAs infinitely, and they shared the dilemma of weighing up waiting lists against non-attended sessions. As some pointed out explicitly, and others perhaps more implicitly, a missed session can feel like wasted time, or, in other words, a slot that could be filled by another patient – indicating their awareness of the cost of not treating other patients, both in terms of money and time (Leavey et al., 2011). I wondered about the extent to which therapists can feel the presence of 'waiting patients' during a non-attended session time; perhaps there is a sense of having to balance the needs of their current patient who is not showing up and an imagined understudy desperate to take their place. Two very experienced therapists observed that pressures on services have vastly increased since they first qualified – an increase which is corroborated by NHS data.[2]

On a therapeutic level, there was a common belief that it can be actively unhelpful to allow a patient to DNA for too long. One participant spoke about the Greek mythological character of Sisyphus, in relation to a dream his patient had had. I felt this illustrated a state which all the therapists seemed keen to avoid – that is, a sense of something becoming endless, repetitive and without progress. It was made clear that DNAs can only be conducive to progress when followed by the opportunity for the therapist and the patient to think about the absence and to begin to understand its meaning together. On a more personal level, participants alluded to how difficult it can be for them to close cases which made me wonder whether the therapists' own feelings about discharging patients who aren't attending – perhaps failure, disappointment,

[2] NHS Digital's Mental Health Services Monthly Statistics show that referrals to Child and Adolescent Mental Health Services in May 2023 were three times higher than in May 2019.

guilt and sadness – can influence their decision making, leading them to hold onto cases longer than might be clinically helpful for the patient. In turn, I wondered whether the boundaries set by the organisation, which can be experienced as rigid and strict, might also serve a helpful function for clinicians, relieving them of the uncomfortable burden of these difficult decisions.

As explored earlier, participants also spoke about the destructive nature of DNAs, and the ways in which missed sessions can feel like an aggressive attack on the therapy. They expressed concern about what might be communicated to a patient if the therapist tolerates DNAs for too long (the word 'colluding' was used a number of times), and emphasised that one should be careful not to join the patient in devaluing or destroying their treatment. Instead, therapists suggested that firm boundaries and limits need to be set; some suggested that firmness can be important and helpful for this age group, and observed that in some cases it was actually at the point of setting a limit that the therapy shifted and progress was made. Interestingly, the participant who I considered to be significantly more boundaried and less tolerant of DNAs than the others struggled to think of any patients she sees who currently DNA. There could be many reasons for this, but it made me wonder whether her firm approach has actually helped her patients to attend. This could reflect the importance of the therapist being able to work in the negative transference; it could help the patient to experience a therapist who is not afraid of being disliked by setting boundaries, or that there is space in relationships for these more difficult feelings (Meltzer, 1967). This idea was supported by another participant who reflected that one of the reasons her patient continued to DNA for so long was because she (the therapist) was initially afraid to inhabit the negative transference and put boundaries in place.

What is clear is the importance of boundaries on both a service level *and* a therapeutic level. Even within an extremely well-resourced service, therapeutic boundaries would still be

essential to help the patient develop and work through the aforementioned conflict between dependency and independence. While displacing the negative transference or boundary setting onto the organisation may bring therapists some relief, this may not be so helpful in the long term. As mentioned, it can be important for the patient to experience a therapist who is able to set ordinary and healthy parental boundaries. However, the struggle with boundaries appears to arise when the therapist experiences a conflict between the needs of the organisation (i.e. to close the case) and the needs of the patient (to have more time for the unconscious communication to be received and understood). To what extent can a young person act out and work through the ordinary back-and-forth between dependence and autonomy when the pressures of the service impinge on the therapy in such a real and concrete way? In turn, does this lead to the young person themselves becoming implicitly responsible for the issue of the waiting lists, in the way they choose to use their therapy? Although the participants named the importance of being realistic, perhaps it is hard to know what this actually means in practice, with such seemingly impossible dilemmas to negotiate.

CONCLUSION

Summary of findings

This study has explored the individual experiences of Child and Adolescent Psychotherapists working with older adolescent and young adult patients who, at times, do not turn up for sessions. The findings have highlighted that working with this patient population is complex, and that there are a number of dilemmas faced by therapists when thinking about how to work with and manage DNAs.

In the context of the therapy itself, clinicians felt it is important to allow space for the young person to act out and to communicate unconsciously through their absence; however, they simultaneously wanted to avoid colluding with this for too long, and emphasised the need to set limits to encourage the young person to attend and help the work to move forwards. Similarly, a balance was sought between considering unexplained absence in relation to the internal world and the unconscious mind, and the external pressures and barriers against engagement for young adults in today's society.

Tensions also appeared to exist on an organisational level. Clinicians acknowledged the reality of long waiting lists and limited resources; however, it was clear that the official policies aimed at reducing DNA rates in their services felt restrictive. This left clinicians with a desire to advocate for the importance of persevering with treatment with patients who miss sessions, and a wish for their organisation to recognise the important role DNAs can play in treatment. They felt strongly that decisions should be made on a case-by-case basis, and not according to a blanket policy. The issue was described as 'political', leading some clinicians to try and find

ways to protect the therapy, and others feeling gratitude towards service management for giving them 'licence' to work with DNAs.

Clinicians made clear the psychoanalytic lens through which they primarily make meaning of their patients' unexplained absences, but it was emphasised that the therapist cannot do the work of understanding absence alone. It is important ultimately that the young person returns to therapy in order to make meaning together. Examples were given where this has led to progress in the therapy.

Strengths and limitations

The small sample size and semi-structured interview style elicited a rich amount of data, with the interview questions prompting a great deal of thought and reflection in the participants. Having a small number of participants and analysing the data using IPA enabled an in-depth examination of the lived experience of participants, and illuminated the details, nuance and dilemmas of their experiences. The fact that participants worked in a variety of different services, had a range of levels of experience, and were of different ages and genders meant that the data was also diverse and offered a range of perspectives.

The limitations of a small sample size must also be acknowledged. One could not assume that the individuals' thoughts and experiences would necessarily be shared by other CAPTs, nor indeed by clinicians of other disciplines working with this patient population, and although there were many shared opinions amongst the participants, it is not possible to generalise the findings.

IPA is an interpretative process, and therefore the way I have made sense of the data will be as unique to me as the experiences described were unique to the participants (Smith & Osborn, 2003). As a CAPT myself, I analysed the data through a psychoanalytic lens, and thus my findings will have been guided by this way of thinking. It is likely that a researcher from a different school of thought, or even another clinician from the same modality, might have interpreted the data in a different way.

Three of the interviews for this study were conducted in person, and two were carried out online, via Zoom. This disparity would no doubt impact the experience of the interview both for me and the participant, and therefore potentially influence the findings, however space is too limited here to explore the deeper implications of this. I did not observe any significant differences in the interviewees' ability to think, reflect and speak openly about their experience, and in the online interviews there was good internet connection so the dialogue could flow easily. Nevertheless, I recognise that there can be certain elements of an in-person experience which may be missing from an online encounter. For example, non-verbal aspects of human interaction, such as body language and communication, and the more sensory aspects of the experience are much harder to pick up on, if at all, when communicating through a screen. This in turn can have the effect of limiting or distorting the interviewer's countertransference.

Future research

Given the participants' need to justify the significance of allowing space to work therapeutically with DNAs in light of service-related pressures, it seems important that there is an evidence base supporting this. The aim of this study was not to negate the importance of thinking about efficient use of resources in public healthcare, but rather to advocate for more

thinking and understanding within organisations around the reasons *why* young people might not attend a therapy session. I also hoped to give clinicians a voice to articulate their experience and understanding of this work, to sit alongside more quantitative studies into non-attendance in therapeutic settings where definitions of non-engagement can be narrower and more simplistic.

The literature review highlighted the lack of distinction in some existing research between failure to attend a first appointment, drop-out, disengagement or missed session as part of ongoing therapy. An exploration into the difference in quality and meaning of each of these could be an interesting research focus, including thinking about how we define 'engagement'; this study's findings, for example, suggest that missed sessions can actually be a sign of engagement and communication.

This project explored the individual experiences of CAPTs. Further research could investigate the way clinicians from different disciplines make sense of DNAs in young adult patients, as well as exploring how psychoanalytic psychotherapists negotiate conversations around DNAs with their colleagues of other disciplines. It could also be interesting to learn about DNAs in private settings, perhaps to discover whether the experience of paying for treatment impacts the occurrence or frequency of DNAs in psychoanalytic work, as well as how a private therapist (who is not facing the same service-level financial pressures) thinks about or works with missed sessions and how the boundaries are managed.

I also found myself curious throughout the project about the feelings and opinions of the young adult patients themselves, and what they might have to say about their non-attendance. Further qualitative research could explore this and potentially illuminate the same subject from a

different viewpoint, as well as looking at the experience of young people who are responsible for bringing themselves to therapy for the first time, and the possible associated expectation that they are to manage 'on their own'. Linked to this, it could be interesting to explore missed sessions as a communication of not wanting to attend therapy anymore, or of wanting to reduce frequency of sessions. The findings of this study suggest that this was a harder communication for therapists to engage with or 'hear' from the patient, instead leaning towards interpreting missed sessions as a defence or an avoidance of dependency – there could be more to understand here about how to receive communication that a young person is ready to end therapy and the positive, developmental aspects of this.

One participant spoke in the interview about young people requesting online or telephone sessions, feeling that this can be a sort of 'half' DNA, whilst another spoke about a patient who could become absent during the session – emotionally, if not physically, disappearing. These ideas felt too tangential to include in the present study's findings, however they do offer scope for future research into the different ways in which young people may avoid being fully present in the therapeutic relationship. What role does the physical presence/absence of the body play in the young adult's negotiation of separation and independence? Another question which could be examined more closely is what happens in the session *after* a DNA, and what the process of understanding or reparation with the patient might entail.

Also mentioned in the literature review was the significantly higher proportion of appointments missed in adult psychological therapy services as opposed to other medical fields. This could be interesting to investigate, perhaps considering where psychoanalytic psychotherapy sits within these statistics.

Clinical implications

This research project has a number of implications for clinical practice. The findings can:

- Support the way CAPTs think about and make sense of missed sessions. They can help clinicians to develop both a theoretical understanding of DNAs in the context of psychotherapy with young adults, as well as to understand their own responses and how these may help them make sense of the patient's experience or communication.
- Support the development of clinical practice with regards to responding to and working psychoanalytically with young adults who miss sessions.
- Help clinicians consider when and how to implement boundaries when DNAs become chronic or ongoing.
- Support clinicians to make meaning of DNAs beyond the practice of psychoanalytic psychotherapy. Missed sessions are not unique to psychotherapy; this project can support clinicians of other disciplines to think about the meaning behind missed sessions and to understand their own emotional responses to DNAs, even if their clinical technique with the patient is different.

Personal reflection

It is important to acknowledge the position from which I have approached this study. Being a Child and Adolescent Psychotherapist myself (now qualified, but a trainee throughout the majority of the research process), my interest in the topic developed out of my own personal and professional experiences. Inevitably my thoughts and feelings were likely to impact the way I conducted the interviews and analysed the data.

I kept a reflexive diary throughout the process of conducting this study. This allowed me to observe my own experience as a researcher, and also to notice when my own personal bias might be influencing my findings, in order to mitigate this where possible. I maintained regular contact with my supervisor and looked through my interview schedule and data analysis with him, in the hope that this second viewpoint might help identify any potential bias. On a more practical level, I conducted the interviews in rooms set apart from those in which I usually work, to try and create some distance and space in my mind from my role as a therapist, and to help me step into the position of researcher. This particularly helped when interviewing a participant with whom I have a professional relationship. Because I was a trainee clinician interviewing qualified professionals, all participants were senior to me in one sense, even if I didn't have a working relationship with them. I wondered whether this made it harder for me to encourage them to explore their personal feelings – particularly in relation to insecurities or self-doubt – or indeed made it harder for them to expose these vulnerabilities to me. Conversely, given the participants knew I was a trainee CAPT, I wondered whether our shared school of thought led them to omit certain things from the interview, assuming common knowledge with me. I remained mindful of this, asking them what they meant or to expand when I felt they were making this assumption.

I wondered whether, due to my own expectations, I might unconsciously be guiding the participants towards certain answers in the interviews. There were certainly many commonalities in the way participants spoke about their experiences, however I was reassured to see there was room and scope for differences, too. It would also be expected that, given the shared modality and therapeutic approach of the clinicians, that certain views would be shared.

I noticed while analysing the data that I had certain expectations about what I might find, owing to my own professional experience. I tried to remain present throughout the analysis, noticing when my mind stepped ahead and began looking for things or jumping to conclusions, and trying to draw myself back to the data and what was in front of me. This was greatly helped by clustering the themes using physical strips of paper, as recommended by Smith & Nizza (2022), rather than analysing the data on screen.

Finally, I noticed that it took some time before I felt able to fully engage with this project. One supervisor observed lightly that perhaps I was 'DNA-ing' on my own research. I reflected on feelings in myself of finding it hard, initially, to get too involved or too immersed in the work, and wondered whether these feelings mirrored something I mentioned earlier about the pain of getting involved with regards to facing limits – the limits of one's ability and scope of the research which perhaps reflect, on a deeper level, the limits of our time in general. As Burkeman writes, when you try to engage with something you deem important, 'you're forced to face your limits, an experience that feels uncomfortable precisely because the task at hand is one you value so much' (2021, p.105). I feel this is perhaps a thread that has weaved through this project in different ways, and which might encapsulate the painful fluctuation between contact and disconnect which seems to sit at the heart of clinicians' experience of DNAs.

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APPENDICES

Appendix 1: Confirmation of Ethical Approval from Tavistock Research Ethics Committee (TREC)

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
Fax: 020 7447 3837

Francesca Wickers
By Email

31 May 2022

Dear Francesca,

Re: Trust Research Ethics Application

Title: How do Child and Adolescent Psychotherapists understand the meaning of non-attended sessions – or 'DNAs' – in psychotherapy with adolescents and young adults? An interpretative phenomenological analysis.

Thank you for sending your response to the conditions set by the Assessor with regards to your TREC application. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Course Administrator

Appendix 2: Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

How do Child and Adolescent Psychotherapists understand the meaning of non-attended sessions – or 'DNAs' – in psychotherapy with adolescents and young adults?

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?

With this study, I aim to explore the way Child and Adolescent Psychotherapists experience non-attended sessions with adolescents and young adults aged between 18 – 25, and how they understand the meaning of these missed sessions.

Who is conducting the study?

My name is Francesca Wickers. I work in the Tavistock and Portman NHS Trust, and I am training to be a Child and Adolescent Psychotherapist. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

Why this project?

My interest in this topic has developed through my work in a specialist psychotherapy service for adolescents and young adults, where I have come to view missed sessions, or 'DNAs', as an integral aspect of the work with this age group. In discussion with colleagues, I have observed a tension between the importance clinicians place on making meaning of, and working therapeutically with, patients' absences, and the pressure of long waiting lists and a desire to avoid wasting resources. Child Psychotherapists often report an improvement in engagement once the communication behind a patient's non-attendance has been brought into focus in the therapy. Others, meanwhile, reach a point with patients who repeatedly do not attend, whereby treatment is withdrawn and the case closed. I would like to understand more about when and how these decisions are made.

I am specifically interested in this age group because, unlike younger children using CAMHS services, most patients attend therapy with little or no parental involvement and are perhaps freer to decide for themselves whether or not to come. I am curious to see whether clinicians consider there to be a link between this emerging adult independence and missed sessions.

What will your participation involve?

You will be invited to take part in an individual interview, offering a space for you to talk freely about the topic, with some questions and prompts from me. I will be interested to hear about one or more patients aged 18-25 with whom you work (or have worked in the past 12 months), who at times have not turned up for sessions. In the interview, I would like to explore what it is like working with such patients, the role you consider these missed sessions to play in the therapy, and how you make sense of the patient's absence. This may include thinking about your own feelings and responses when a patient does not turn up. I will also be interested in whether you have had to consider closing a case as a result of non-attendance, and if so, how this decision is approached.

Interviews will last approximately 1 hour, and will be audio recorded. I hope to conduct these in person, but if this is not possible then they will take place via video link or telephone. If it is possible to conduct interviews in person, this will be at your usual workplace at a time that suits you. No extension to your usual working hours will be necessary.

Do I have to take part?

No, it is completely your choice whether or not you take part in the study. If you agree to take part, you can withdraw without giving any reason, any time up to three weeks after the interview. After this time, the data will then be processed and analysed. If you do decide to withdraw, all data collected will be destroyed immediately.

To take part in this study, you will need to:

- Be a qualified Child and Adolescent Psychotherapist
- Work in a service offering psychotherapy to young people aged 18-25
- Have experience of patients not turning up for sessions (as opposed to cancelling in advance)

What will happen to any information I give?

The UK-based Tavistock and Portman NHS Foundation Trust is the sponsor for this study. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 5 years after the study has finished. The interview will be audio recorded and transcribed by me.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

Quotes from the transcript will be used in the write up of the project but these will be de-identified. However, please note that it is possible that you may be able to identify yourself in the final report, and that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:
https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/
https://www.ghc.nhs.uk/privacy-notice/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

What will happen to the results of the project?

The results of this study will be used in my Research Dissertation Project and Doctorate Qualification. It may also be used in future academic presentations and publications.

I would be happy to send you a summary of the results if you wish. Please contact me to request this if it is of interest to you.

What are the possible benefits of taking part?

There will be no direct benefits for you. However, by taking part you will be given the opportunity to reflect on your therapeutic understanding of patient engagement. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work.

Are there any risks?

No, there are no direct risks. However, details of a confidential service you can access for emotional support will be provided if needed.

Contact details

I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Francesca Wickers
Email: FWickers@tavi-port.nhs.uk
Address: The Tavistock Clinic, 120 Belsize Lane, London NW3 5BA

Alternatively, any concerns or further questions can be directed to my supervisor:

Dr Danny Isaacs

Email: DIsaacs@tavi-port.nhs.uk

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project, please contact Beverly Roberts, Head of Academic Governance and Quality Assurance (BRoberts@tavi-port.nhs.uk).

Thank you for considering taking part in this study and taking the time to read this information.

If you are willing to take part in the research, please complete the consent form provided.

Appendix 3: Participant Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Consent Form

Project title: How do Child and Adolescent Psychotherapists understand the meaning of non-attended sessions – or 'DNAs' – in psychotherapy with adolescents and young adults?

Name of researcher: Francesca Wickers

- I, _____, voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed, as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
- I understand that direct quotes from the audio recording may be used in this research study, that these will be made anonymous to the reader and held securely by the researcher, but that I may be able to identify myself in the final report. ☐

- I understand that it is my responsibility to anonymise any examples referring to cases I choose to discuss during the interview. ☐

- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Francesca Wickers

Email: fwickers@tavi-port.nhs.uk

Supervisor: Dr Danny Isaacs

Email: disaacs@tavi-port.nhs.uk

Participant's name (printed):

Participant's signature: Date:

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Appendix 4: Participant Debrief Letter

The Tavistock and Portman NHS
NHS Foundation Trust

Dear

I am writing to thank you for your contribution to my Doctoral Research Project. I hope you found the experience a helpful one, and I value your participation in the interview.

If there are any issues that are concerning you, I hope that you can access the support network around you (colleagues, supervisor and managers) or the Human Resources department of the organisation in which you are currently employed. If you have any questions or would like further information, here are my contact details:

Email: FWickers@tavi-port.nhs.uk
Phone: 07892 979 459

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Danny Isaacs (DIsaacs@tavi-port.nhs.uk), or Beverly Roberts, Head of Academic Governance and Quality Assurance (BRoberts@tavi-port.nhs.uk).

Best wishes,

Francesca Wickers