The next attended session after no-show sessions in Short-Term Psychoanalytic Psychotherapy: a qualitative analysis of audio recordings

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Abstract

Background: Three types of dropouts have been identified in research using the IMPACT study dataset, which is a clinical trial in which the effectiveness of different types of therapy for adolescents with depression is compared. One type of dropout is referred to as a 'dissatisfied' dropout who stopped therapy because he/she did not find it helpful. However, little is known about the in-therapy process of this group. Hence, the aim of this study is to explore the dissatisfied dropout's in-therapy process through the entry point of a reunion session, which was the first session attended after missing sessions.

Method: Five reunion sessions, one for each of five adolescents with depression, were drawn from the IMPACT study. The transcript of audio recordings was analysed using thematic analysis.

Results: Four main themes were identified: Absence and reunion, Sense of helplessness, Turning to peers, and Signs of withdrawal. The theme of a sense of helplessness was presented in three of the five patients. Signs of withdrawal was the most common theme presented in four of the five patients. A specific type of withdrawal, 'Passive withdrawal', was identified in one patient, which was characterised as feelings of resignation and passivity.

Conclusions: Dissatisfied dropouts' affect and relationship perspectives in the reunion sessions were explored. The implication of future research of psychotherapy with adolescents is reflected in this dissertation, which indicates that more research on dropouts and dissatisfied dropouts is needed to reduce obstacles for adolescents to attend therapy.

Keywords: Adolescents, dropouts, dissatisfied dropouts, helplessness, in-therapy process, reunion, withdrawal, passive withdrawal

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Content

Chapter 1: Introduction

The aim of this study is an attempt to understand a group of adolescents who dropped out from psychotherapy, especially those who dropped out due to feeling dissatisfied with their therapy. In this chapter, I shall elaborate how and why I became interested in this subject and what I wish to learn from it.

The subject of this study is actually not my first doctoral research proposal. As an overseas student, I initially wished to conduct a study that I could 'bring something back' to my home country; therefore, my first proposal was an exploration of clinicians' experience working in the mental health services of the UK and my home country, with the aim of determining what we can learn from each other. For various reasons, this project did not proceed, which was not disappointing for me, as I thought it was not very clinical, and I wanted to contribute to the mental health system in my home country.

In my early years of the doctoral training of child and adolescent psychotherapy, the colleagues in my year group and I were looking forward to the publication of the results of 'unprecedented psychotherapy research'. This research involves improving mood with psychoanalytic and cognitive therapies, the IMPACT study (Goodyer *et al.*, 2017), a large scale, multiple centre quantitative study comparing the

effectiveness of Brief Psychosocial Intervention (BPI), Cognitive Behavioural Therapy (CBT), and Short-Term Psychoanalytic Psychotherapy (STPP) for depressed adolescents. I remember the day that the results were made known to my year group. I was so disappointed and discouraged that the results indicated that STPP was no more effective than the control group (BPI). However, when I learned later how BPI works, I understood why it can be effective.

More IMPACT study-related studies were published within a couple of years, which portrayed different trajectories of patients' improvement by Aitken *et al.* (2020) and Davies *et al.* (2020). A series of qualitative studies was also published, IMPACT-ME (My Experience). For example, O'Keeffe *et al.* (2019) identified three types of dropouts based on part of the IMPACT study participants, one of whom are 'dissatisfied' dropouts, who stopped attending therapy because they did not find it helpful. Although dissatisfied dropouts did not have significantly poorer outcomes than completers, O'Keeffe, Martin and Midgley (2020) found that dissatisfied dropouts had poorer therapeutic alliances, more ruptures, ruptures that were frequently unresolved, and greater therapist contribution to ruptures. I was amazed and inspired by the results of these series of studies. I used to find quantitative research on psychotherapy unhelpful, as I thought the internal process and the therapeutic relationship issues were neglected in this research approach. However,

very rich and meaningful findings were revealed in qualitative IMPACT-ME studies because they shared a dataset with quantitative IMPACT studies, and the two methodological approaches were combined. Therefore, I felt in a very 'imprinted' way, not just an unforgettable one, how unprecedented the series of IMPACT studies were. In my early years of training, as a trainee who had not decided the subject of his doctoral research, I wondered whether I could take the opportunity to make use of this dataset to answer some of the clinical questions in my mind.

From my clinical experience, no matter what kind of impasse my patients and I were stuck in, as long as the dynamic was not sadistic or perverse and as long as they come, I am willing to take it slowly, just wait and see what patients bring to our sessions. However, I am left with worries about patients who stop attending when we are stuck in an impasse, or just stop attending for unknown reasons. Although I understand that there may be some other helpful resources in their lives, my concern is that, if they encounter difficulties and choose to bear them or suffer from them on their own instead of reaching out for help, it may become a vicious cycle that isolates them, and that not getting help will make their difficulties worse, and they will not be known by others around them. Another concern is that, if they stop attending due to some dissatisfaction with the therapy, this unresolved dissatisfaction becomes an obstacle for them to make use of help that is offered to them in the future. Beyond

my concern for dissatisfied dropouts, I am deeply intrigued by this group, specifically in terms of how they present in sessions, the nature of their relationship with the therapist and how they make use of their therapy. It was this combination of professional concern and intellectual curiosity that led me to choose this group as the subject of my dissertation. Therefore, I decided to research the following question to determine what could be learned from the IMPACT study dataset: what are the sessions of dissatisfied dropouts like before they stop attending?

As the sole investigator for this study, I can only analyse a limited number of sessions; hence, the selection of meaningful material is a critical consideration. As discussed in the subsequent literature review, various authors have addressed the association between missed sessions and dropout. Gans and Counselman (1996) regarded missed sessions as valuable opportunities for therapeutic exploration and, from my clinical experience, the next attended session most frequently provides the best opportunity to explore the meaning of a missed session. In this study, the next attended session following a missed session (or missed sessions) is referred to as a 'reunion session'.

In the IMPACT study reviewed in the next chapter, cases classified as 'dissatisfied dropouts' revealed their dissatisfaction with the therapy during post-treatment interviews. Consequently, selecting reunion sessions from the later stages of therapy,

rather than the earlier ones, may better capture the in-session processes that precede the decision to discontinue treatment. Therefore, I have decided to use dissatisfied dropouts' reunion sessions that occurred close to their last attended session as the primary material for this research.

Chapter 2: Literature review

Due to the limited number of studies of adolescents' non-attendance/dropout in psychoanalytical psychotherapy in the literature, I have also included studies of non-attendance/dropout in mental health services, and psychotherapy/psychological therapy with children and adults.

2.1 Non-attendance

The non-attendance of appointments is a huge issue in mental health services and the healthcare system in general. It was stated in a report by Gier (2017) that missed appointments in healthcare services in the United States caused around $150 billion of financial losses each year and no-show rates in general are as high as 30%. Missing appointments are highly related to dropouts (Kazdin, 1998) and may cause a longer wait list and the underutilisation of services. According to a report by collegiate mental health centres (Pennsylvania State University, 2020) which consist of approximately 600 university and college counselling centres, missing appointments (no-shows or cancellations) account for 26.2% of the reasons for closing a case .

2.1.1 Types of non-attendance

There are three types of non-attendance of therapy: missed sessions, cancelled sessions,

and no-shows. These were simply, but clearly, defined by Gans and Counselman (1996): ‘A missed session occurs when therapist or patient, or both, do not meet at their scheduled time. Some missed sessions are cancelled sessions— either party has given prior notice to the other of being unable or unwilling to attend a mutually scheduled session. Other missed sessions are “no-shows.”’ As this dissertation is focused on patients’ non-attendance, these three types of non-attendance will be used to refer to patients’ non-attendance, rather than therapists’.

In my experience of clinical training in a community (CAHMS) in north London, the definition of a ‘cancelled appointment’ in our team was patients’ non-attendance with notice being given before the end of the scheduled session. If no notice was given before the end of the session, i.e. no-show, it was coded as “DNA (did not attend)” in our mental health record system.

The term ‘missed’ sessions is more ambiguous or broader, as it sometimes refers to no-shows or cancellations at short notice, e.g. DeFife *et al.* (2010) define missed appointments as those that were ‘either cancelled with less than 24 hours’ notice’ or the patient did not show up’. O'Keeffe *et al.* (2018) define a missed session as ‘a session that had been scheduled but that the young person neither cancelled in advance nor attended, as recorded by the therapist’. Patients’ cancellation, even with very late notice,

conveys direct communication with the therapist or organisation about their absence. However, for no-shows, especially in cases where no notice was given at all, there is no direct communication by the patient as to why he failed to attend the session, and the therapist is left wondering why he did not turn up until their next contact. Moreover, external factors, including unexpected events, accidents, stressful events, and internal factors, such as patients' motivation, emotion, reluctance to engage, etc., also contribute to their absence. Therefore, according to Gans and Counselman (1996), 'missed sessions, whether initiated by the patient, therapist, or nature, are events in psychotherapy, not non-events.'

2.1.2 Rate of missed sessions

There are more studies in the literature about the percentage of missed sessions in outpatient psychiatry departments or mental health services than the percentage of missed sessions of patients in psychotherapy/psychological therapy.

As for research investigating organisations' overall non-attendance rate, DeFife et al. (2010) found that 2% of appointments were late cancellations (notice given within 24 hours) and 13% of them were no-shows. The pattern of missed appointments (including late cancellations and no-shows) showed that 21% of the patients had only missed one appointment, 27% had missed two or three, and 13% had missed four or more. In

Mooney and Johnson's research (1992), 13.7% of the appointments were cancelled, and 17% were no-shows, while Miller-Matero *et al.* (2016) showed that the average rate of missed appointments was 15.38%.

Chariatte *et al.* (2008) studied patients aged 12-20 years, and found that 45% of them did not miss any sessions, and 14% of females and 17% of males missed a quarter of their scheduled appointments.

2.1.3 Risk Factors and Characteristics of Non-attendance

Compared to dropout, studies of predictors of non-attendance are more limited (Chariatte et al. (2008), Coodin *et al.* (2004), Feitsma, Popping and Jansen (2012), Gordon *et al.* (2010), Jensen-Doss and Weisz (2008), Kirk and Frank (1976), Kivlighan *et al.* (2018), Miller-Matero et al. (2016), Xiao *et al.* (2017)).

Based on demographic predictors, older male patients, who had previously missed sessions were at more risk of cancelling the next to last appointment. For those aged 18-79 years, being younger and living more than 30 miles from the clinic were predictive factors.

Sociodemographic predictors: lower income.

Patients' features: missing 20% or more sessions is related to drugs and alcohol abuse, and lower community functioning, impulsiveness, and limited reading ability.

Family factors: missed sessions are related to less family social support, history of maternal depression, having a single parent or one who had never married.

Clinical features: the group with eating disorders and psychiatric diagnoses previously missed sessions and a longer gap between appointments increased the risk of missing; depression, sleep difficulty and limited reading ability were also found to be predictive factors.

Treatment factors: the majority of missed appointments were in the beginning phase; diagnostic agreement between clinician- and researcher-generated diagnoses predicted better therapy engagement and less dropout.

Therapists' effect: the therapist's effect is significant (rate of missed sessions differed between therapists) after the third attended session; for some therapists, racial/ethnic minority REM patients' non-attendance rates were higher compared to those of white patients.

2.1.4 Reasons for non-attendance

DeFife et al. (2010) explored the different patterns and reasons for patients' no-show to psychotherapy appointments with a focus on "missed appointments ", which refers to appointments that were either cancelled with less than 24 hours' notice or the patient did not show up for the appointment. The clinicians' explanations for the patients' cancellation were grouped into four themes: clinical problems (21% of missed appointments), e.g. sick, fatigue/overslept, or feeling overwhelmed; practical matters (26%), e.g. weather issues, transportation problems, childcare issues, or other conflicting schedules; motivational issues (17%), e.g. patient forgot appointment, patient found it difficult to prioritise self-care; and negative reaction to treatment (13%), which describes some treatment-related issues whereby the patient and/or the clinician encountered difficulties in the treatment context, such as frame disruption, e.g. patient was consciously or unconsciously motivated to miss sessions due to the clinician cancelling or rescheduling a previous session); reaction to therapy process, e.g. patient had a negative reaction to the method of treatment employed; and psychological avoidance, e.g. patient avoided intimacy. In Granås Granås, Strand and Sand's (2023)'s study[1] it is suggested that adult patients reported that the mental illness that had caused them to be referred for treatment also caused their absence, e.g. feeling too depressed to go out made them feel ambivalent about whether or not they could achieve change.

[1] Granås (2023)- A patient perspective on non-attendance for psychotherapy in psychiatric outpatient care for patients with affective disorders

Other researchers presented reasons for non-attendance as forgetting about the appointment and work commitments (Feitsma, Popping and Jansen (2012)), poor patient–staff relationships and missing appointments was seen as making relationships worse (Cirasola *et al.*, 2021), mental health no-show patients were more likely than medical no-show patients to cite external factors like a broken-down car or a scheduling conflict, to explain why they had missed an appointment (Tidwell, 2004).

2.1.5 Influence of non-attendance

According to the 'Dose-effect model' of Baldwin *et al.* (2009), small doses of treatment were related to relatively fast rates of change, whereas large doses of treatment were related to slower rates of change. Howard *et al.* (1986) indicate that approximately 50% of patients have measurably improved after 8 sessions, and approximately 75% of them have improved after 26 sessions. In some studies, it was found that a higher no-show rate in the earliest phase of treatment is more damaging because the first several sessions are the key phase for the development of the therapeutic alliance (Fluckiger *et al.*, 2012). Xiao et al. (2017) found that only no-shows had a negative impact on the magnitude and rate of symptom changes, and the impact is greater when it happens before the third session.

The impact of patients' missed sessions on therapeutic factors is an understudied area.

This may be partly because the issue of non-attendance is generally studied using quantitative methods, and there have been few qualitative studies, e.g. interviewing therapists to determine their experience of the impact of patients' non-attendance on the therapeutic structure or process, and their view of whether patients' non-attendance only interrupts the therapy, or whether it serves another function that can help to understand patients' difficulties.

2.1.6 Strategies to reduce patients' non-attendance

Non-attendance is usually followed by dropout, which means that resources are underutilised. Different strategies to reduce non-attendance are recommended by different researchers. For instance, Branson, Clemmey and Mukherjee (2013) show that text message reminders can increase adolescents' attendance from 49% to 65%, and text message reminders receive high patient satisfaction ratings. According to Boyle and Schwinck (2022), practitioner-initiated telephone orientation protocol, which includes an attendance policy review, psychoeducation, and motivational interviewing techniques, can reduce the rate of missed appointments by 55% over 12 weeks. Browne and Dolan (2007) found that many psychodynamic clinicians utilised written communications to interpret their patients' non-attendance. Ingrassia Ingrassia (2003) suggests that using letters to resolve the impasse can be helpful for engaging when they

have been carefully thought through.

2.2 Dropouts

Withdrawal from psychotherapy can be classified into two groups, one of which consists of ‘non-starters’ and the other of patients who dropped out after attending the first appointment. The non-starters are those patients who have not attended any therapy sessions; in other words, they missed their first appointment with the service, and then failed to take any further treatment. The other group consists of ‘dropout’ patients, who did not attend the sessions offered to them at a certain point after starting their therapy.

It can be quite concerning that non-starters and patients who drop out very early in their therapy may continue to suffer from the issues that caused them to be referred to the mental health services in the first place. However, this may not always be the case. Manthei Manthei (1995) conducted research about the follow-up calls made to non-starters and patients who had only attended one session (‘one-session only’ clients), and found that more than 50% of each group reported improvement. The reasons given by non-starters for improvement included self-improvement effort and having counselling elsewhere, whereas one-session only clients claimed that they had benefitted

sufficiently from their single session. As non-attendance and dropout during the course of patients' therapy are the focus of my research, I did not include more studies regarding non-starters in the literature review.

Dropout of therapy of children and young people is a significant issue for mental health services. To some extent, this is a different issue from non-attendance, but it may also be similar, as patients decide not to attend their sessions before the planned ending in both cases. There is more extensive research on dropout than on non-attendance, and it has been studied from various perspectives. Nevertheless, it is difficult to integrate or compare the results of these studies as they contain various definitions of dropout. This is why Armbruster and Kazdin (1994) (as cited by O'Keeffe *et al.* (2018)) describe studies of dropout as 'definitional chaos' 'because inconsistencies are the rule rather than the exception'. O'Keeffe et al. (2018) also found that another issue regarding this subject is that fewer researchers have studied depressed adolescents than other patient groups.

2.2.1 Chaotic Definitions of dropout

Researchers who have studied dropout have produced contradictory findings. One of the reasons for these different findings is that there are diverse operational definitions of dropout. O'Keeffe *et al.* (2018) and O'Keeffe *et al.* (2019) explain that most

researchers use one of three of them: (1) Based on the therapist's judgement: the therapist judges whether the patient has made a decision to end the therapy prematurely and without a mutual agreement (unilateral ending); (2) Based on the patient's actions: whether the patient attended or missed the last scheduled appointment, and the latter is classified as dropout; (3) Based on the treatment duration: a specific number of sessions is defined and failure to attend them all is classified as dropout. The dropout rate can differ in studies if different definitions are used. For example, Warnick *et al.* (2012) used different definitions to compare the dropout rate and found that it was 56% when the definition was 'missing the last scheduled appointment' and 88.1% when the definition was 'completing fewer than 12 sessions in four months'.

O'Keeffe *et al.* (2018) discussed the issues that can arise due to the chaotic definitions of dropout. Although the dropout rates are similar when using the therapist's judgement (definition 1) and missing the last scheduled session (definition 2), it is problematic to compare the results between studies that contain different definitions. A patient may meet the definition of dropout in one study, but may not meet it in others, which implies that the results of a study may change if different definitions are used. This is especially an issue for definition 3, as whether a patient is a completer or dropout is rated based on a predefined number of attended sessions and this dichotomised approach is problematic. Although the advantage of this definition is its objectivity, the rating can

change when the threshold changes. Moreover, the lack of a clinical implication is a problem, as there can be individual differences in terms of the number of sessions needed for a patient to make progress, and dropout may occur at any point in the therapy (Wierzbicki and Pekarik, 1993). Therefore, it is difficult to find a specific number of meaningful sessions, and this is especially problematic for open-ended therapy.

With regard to defining dropout as missing the last scheduled appointment (Definition 2), this can refer to two situations, one of which is the patient missing the planned final session of the whole treatment, while the other is the patient repeatedly missing sessions, and then having no further contact with the therapist (Swift and Greenberg, 2012). The advantage of this definition is its objectivity, but there are some issues with using Definition 2. The main issue is the lack of considering the clinical importance of attending the final session(s), and hence, missing whether ending the therapy is a clinically appropriate decision or not. For example, if a patient wants to end his therapy against the therapist's advice, he is classified as a completer as another appointment has not been scheduled. On the other hand, the patient's ending of therapy may be clinically appropriate, but it can be classified as a dropout if he misses the final session.

The definition of dropout due to the lack of a mutual agreement to end the treatment (Definition 1) is usually based on the therapist's report. It is understandable that it would

be much harder for the patient to report it because those who drop out are unlikely to stay in touch with the therapist or the service. Based on O'Keeffe *et al.* (2019) the advantage of this definition is that the clinical implication is clearer than in other definitions, as dropout is based on the therapists' judgement. The disadvantages include the fact that this approach is subjective; hence, the rating may be subject to the criteria of the therapist or therapeutic orientation.

2.2.2 Dropout Rate

About 30% of adult patients attend the first psychotherapy session, but fail to attend the second, and the general dropout rate is 40-60% for psychotherapy. The dropout rate of young patients is 28-75% (Clarkin and Levy, 2004).

de Haan *et al.* (2013) compared the dropout rate in studies based on the use of different definitions (Group 1: Definition 1, Group 2: Definitions 2&3) and different study designs. One of the two types of study designs was effectiveness, which consisted of studies based on a naturalistic setting, and the other type was efficacy, which are randomised control trials. The mean dropout rate in efficacy studies (N=17) was 28.4% (range: 16-50%), and the mean dropout rate in effectiveness studies (N=30) was 50% (range 17-72%). When using different definitions, the mean dropout rate in Group 1 (N=28) was 35.8% (range: 20-63%), and the mean dropout rate in Group 2 (N=21) was

44.5% (range 16-72%). For Group 2, the results indicated that the dropout rate depended on the specific number of sessions used to define dropout. In the subgroups of Group 2, the range of dropout rate was 27-47% when the dropout rate was defined as not completing the whole course of treatment. The range of the dropout rate was 16-31% when dropout was defined as termination before the sixth session, and the range of dropout rate was 18-69% when dropout was defined as termination after the sixth session (e.g. completing a specific percentage of the whole course of treatment, e.g. 2/3 or 80%, or being unable to attend a specific number of sessions, which was more than six), In summary, although the dropout rates varied within the groups, they would have been higher if the criteria of completers used were stricter (e.g. more sessions to be attended). In general, the mean dropout rate was lower in efficacy studies (28.4%) than effectiveness studies (50%). In effectiveness studies, the dropout rates were lower when dropout was defined by the therapist's judgement (45.3%) than the specific/percentage approach (59.8%). On the contrary, in efficacy studies, the dropout rates were similar between the two groups of definitions (26.4% vs. 29.2%). This caused the researcher to wonder if the motivation for efficacy studies is greater than that for effectiveness studies. Another interesting finding was that the specified number/percentage of sessions was often determined by a theoretical approach in the efficacy studies, but in the effectiveness studies, the specified number/percentage of sessions seemed to be 'based

on previous experience' and an unclear rationale.

2.2.3 Predictors of Dropout

There are many studies of the different predictors of dropout, as summarised below (Armbruster and Kazdin (1994), Baruch, Vrouva and Fearon (2009), Edlund *et al.* (2002), Eslinger, Sprang and Otis (2014), de Haan *et al.* (2014), Gonzalez *et al.* (2011), Jankowsky *et al.* (2024), Johnson, Mellor and Brann (2008), Kazdin, Mazurick and Bass (1993), McGovern *et al.* (2024)).

Demographic predictors: adolescence (compared to adulthood), and younger (female) parents for adolescents.

Sociodemographic predictors: lower socio-economic status and low family cohesion, living far away.

Patients' features: poor motivation, viewing mental health treatment as being relatively ineffective and embarrassing, history of antisocial behaviour/delinquency, academic and educational dysfunction, currently in contact with antisocial peers, homeless.

Family factors: high stress and more adverse life events, adverse family childrearing practices, mothers with a history of antisocial behaviour in their childhood.

Clinical features: multiple (comorbid) diagnoses, experiencing family problems or disorderly conduct and ADHD.

Treatment factors: receiving single-modality treatments (compared to both medication and psychotherapy), no-show at least once in the first four sessions of therapy, poor alliances.

Mixed findings: older age (for adolescents), younger age (for all age in general).

2.2.4 Reasons for dropout

Compared to the predictors or risk factors for dropout, the numbers of studies on the reasons for dropout are limited because dropout usually follows no-show; hence, there is little space left for the patient and the therapist to discuss why the patient did not want to come back. The research on the reasons for dropout are based on two perspectives, one of which is the therapist's and the other is the patient's.

Therapist's perspective

Therapists were interviewed in some studies in order to explore why their patients had dropped out from therapy. The reasons they gave are categorised as follows (Bischoff, Krenicki and Tambling (2019), Renk and Dinger (2002), Westmacott and Hunsley

(2017));

For positive reasons: progress being made or goals being met. This was the most important reason for dropping out after the third session.

For negative reasons: no show/no response: dissatisfied with therapy services, not ready for change/insufficient motivation.

Practical reasons: school break, and time/scheduling issue, seeking help elsewhere.

Patient's perspective

O'Keeffe *et al.* (2019) interviewed some adolescents who had dropped out from the IMPACT study and identified three types: (1) 'dissatisfied' dropouts, who did not find the therapy helpful and felt that it had failed to meet their needs. Some of them found it difficult to tell the therapist that they were dissatisfied with the therapy, in which case the therapist tended to report that the ending was due to the patient's inability to engage in the therapy, but seemed to be unaware of the patient's criticism; (2) 'got-what-they-needed' dropouts found that the therapy had been helpful and it had contributed to a positive change in their lives, but they had stopped attending because they had the help they needed. In these cases, the therapists tended to report the same view and they were not clinically concerned about the patient. They regarded the ending as being premature

because they thought that the patient would have benefitted more by continuing the therapy; (3) ‘troubled’ dropouts found it difficult to engage in therapy due to a lack of stability in their lives and to difficulties beyond their low mood (e.g. homelessness, history of abuse and trauma, and financial and caring responsibilities). The therapists shared the same view that the lack of stability needed to be dealt with before the patients engaged in therapy. Some patients found the therapy helpful, and some did not.

2.2.5 Influence of dropouts

The findings of research in which treatment outcomes were compared between patients who completed the therapy (completers) and those who dropped out (dropouts) remain quite mixed. In a study of Cognitive Therapy for Adults by Cahill *et al.* (2003), 71.4% of completers achieved a significant clinical change compared to only 13% of dropouts. Research conducted by Pekarik (1992) included adults (aged 28 years on average) and young people (aged 9 years on average). In terms of adults, ‘dissatisfied dropouts had more inferior outcomes than ‘problem improved’ dropouts and ‘environmental obstacle’ dropouts. As for children, ‘dissatisfied’ dropouts and ‘environmental obstacle’ dropouts had more inferior outcomes than ‘problem improved’ dropouts. In the study of O'Keeffe et al. (2019), there was no significant difference in the treatment outcomes of completers and dropouts. Furthermore, there was not a statistically significant

difference between ‘dissatisfied’ dropouts compared with completers.

Kazdin (1998) studied patients aged 4 - 13 years, and found that dropouts showed greater impairment at home, at school and in the community, compared to completers but the differences were less evident after controlling pretreatment child severity of dysfunction. In Kazdin and Wassell (1998) of patients aged 3-13 years with aggressive and antisocial behaviour, completers had better outcome, but 34% of dropouts’ improvement was similar to completers. Pina *et al.* (2003) found that for patients aged 6-16 years, they showed that there was no significant differences between completers and dropouts.

Those findings suggest that more research is needed to investigate the relationship between the completion of therapy and treatment outcomes. Some factors may need to be investigated in subgroups, for example, age groups of children, adolescents, and adults; clinical features of externalisation (aggressive and antisocial behaviour) and internalising issues (depression and anxiety); and reasons for dropping out.

2.2.6 Strategies to reduce the number of dropouts

As the unalleviated difficulties and wellbeing of patients who drop out from their therapy remain a concern, different clinicians have recommended different strategies.

For example. Reis and Brown (2006) recommends providing new patients with videotaped instructional material to introduce them to what they may expect in the therapeutic process. Hatchett (2004) recommends eight strategies for therapists to reduce dropout in university counselling centres. These include increasing the awareness of risk factors associated with premature termination, preparing students for therapy, developing shared expectations about the content, tasks and goals of therapy, developing client-friendly intake procedures, building termination into the treatment plan, acting as if the therapy will be brief (it can always be lengthened later), continuously monitoring clients' progress throughout the therapy, and utilising appointment reminders. Barrett *et al.* (2008) proposed five strategies, which included role induction (preparing clients for what will happen in therapy), motivational interviewing (facilitating patient's motivation to increase the likelihood to begin, continue, and adhere to the therapy), using a treatment services model (recognising the patient's potential barriers to treatment, e.g. lack of motivation, long waiting list; and encouraging autonomy, highlighting strengths rather than weaknesses, and normalising problems), therapist feedback (a 'patient-focused' approach in which the therapist provides feedback about the patient's progress on a regular basis), and the therapeutic relationship (facilitating a therapeutic alliance).

2.3 Other perspectives

2.3.1 Alliance

As Diamond *et al.* (2006) summarised, a therapeutic alliance is associated with the outcome of the treatment. According to the studies of adult therapy that she reviewed, a therapeutic alliance is established by the third or fourth session, and the outcome can be better predicted by an early alliance than a later one. However, the meta-analysis of Fluckiger *et al.* (2012) did not support this finding, but instead suggested that the role of the researcher was as a moderator between an early alliance-outcome relationship and that the studies conducted by researchers who were interested in a therapeutic alliance had a higher alliance–outcome relationship than those of researchers without a clear interest in a therapeutic alliance. Apart from this contradictory finding, these results indicated a robust alliance–outcome correlation, even in different study designs, disorder-specific manual usage, specific outcomes, and whether or not the treatment was CBT. The meta-analysis of Horvath *et al.* (2011) also supports a significant correlation in adult studies. The number of studies that are focused on children and adolescents is more limited than those that are focused on adults. In Kazdin and McWhinney (2018) indicate that the relationship between a parent-therapist alliance and therapeutic change was explored and it was found that a stronger alliance was associated with greater therapeutic change, and that this remains significant, even if pretreatment factors are controlled. Moreover, interpersonal relationships and the

quality of daily life can predict the quality of the therapeutic alliance. O'Keeffe *et al.* (2018) suggest that a poor therapeutic alliance early in the treatment can predict dropout in adolescents who are receiving therapy for depression.

Safran, Muran and Eubanks-Carter (2011) defines a rupture in the therapeutic alliance as tension or the breakdown of a collaborative relationship between the patient and therapist. In their review, Bengardi *et al*. (2025) observed that ruptures in the therapeutic alliance are often categorised as being withdrawn or confrontational, and the former includes "movements away" from therapy or the therapeutic relationship, reflecting emotional distancing or disengagement between the patient and the therapist, e.g. denial, minimal verbal responses, shifting topics, or intellectualising issues in order to avoid emotional connection. Meanwhile, the latter include "movements against" the therapeutic process or the therapeutic relationship itself, which frequently increase tension, frustration or dissatisfaction, and may involve direct resistance to the therapist's interventions or to the therapy as a whole. Safran, Muran and Eubanks-Carter (2011) conducted a meta-analysis of therapeutic alliance ruptures and summarised some rupture-repair interventions that therapists can apply: repeating the therapeutic rationale, changing tasks or goals, clarifying misunderstandings on a surface level, exploring relational themes associated with the rupture, linking the alliance rupture to common patterns in the patient's life, and a new relational experience.

These results indicate that the presence of rupture-repair episodes is positively related to a good outcome, and that rupture resolution training/supervision can be beneficial for patients' outcome. O'Keeffe, Martin and Midgley (2020) found that dissatisfied dropouts had poorer therapeutic alliances, more ruptures, ruptures that were frequently unresolved, and greater therapist contribution to ruptures.

2.3.2 Psychoanalytical perspectives of missed sessions

Gans and Counselman (1996) summarised some of the core psychoanalytical perspectives of missed sessions, as they wrote in the beginning of their paper,

> 'Missed sessions, whether they are initiated by the patient, therapist or nature, are events in psychotherapy, not non-events. When appropriately handled, missed sessions provide valuable opportunities for therapeutic exploration.'

Although this paper was based on a setting of adults' privately paid analysis/therapy, it is still inspiring when working with patients of other age groups, including adolescents. These authors also emphasised that missed sessions

> 'deeply involve both patient and therapist around commitment, finances, responsibility, self-interest, power, and reality. In addition, they mobilise powerful wishes and fears and crystallise core aspects of transference, countertransference

and the therapeutic alliance.'

It is not uncommon for a discussion of a missed session to become the major subject of the therapy, resulting in either deepening the current work or an impasse, which risks the termination of the therapy. They list the common reactions to missing sessions, ranging from profound loss, to enormous anxiety, to great relief, to sheer indifference. It may leave the patient and the therapist thinking about what the other is doing, what the other feels about seeing them, whether the other misses them or thinks about them, etc. The authors also suggest that the patient's response to a cancelled/missed session may reflect the phase of the therapy.

They propose that

'a missed session is a dynamic occurrence. Sometimes its motives are unconscious; at other times, conscious but uncomfortable, feelings prompt the cancellation.'

A missed session may convey positive dynamics, e.g. patients feeling able to free themselves from constraints. It can be like playing peek-a-boo in the early years to test object constancy. It can be an opportunity for the patient to abandon an important other to overturn a sense of passive victimisation. In fact, a missed session may have different layers of meaning, which require much time for further exploration.

2.3.3 Psychoanalytic perspectives of adolescent development

According to Meltzer and Harris (2011), the psychological development of adolescents is a process of navigating between different 'groups/communities'. Thet first is the pubertal group. After latency, pubescent youngsters form a community of people of their own age; at first, it is a group of one sex, either boys or girls. Meltzer called these groups ‘gangs’, and he described them as follows;

> ‘Initially these gangs may be in a state of revolt against the adult world and have the aim of carrying on the war of the sexes: they are bands of guerrillas who launch small attacks on other groups and bring back trophies of sexual experiences, which represent the part of the partner’s body which is considered to have been occupied during the sexual battle.’

By finding a group or gang, youngsters can talk in terms of “us” instead of “I”, and this group identification is one of the main reasons for these groups to be formed. Meltzer commented that:

> ‘puberty is the moment of greatest madness in a person’s development. In my opinion, the period spent in the homosexual group is essential for the individual’s development, in order to avoid

> either taking a step backwards towards isolation, or clinging to the family, or diving into a tunnel, feeling obliged to get to the end.'

Over time, there is a transition from the pubertal group to the adolescent community. They begin to leave the pubertal group and form couples as they become friends with members of the opposite sex. These couples begin to form a new group, which is the real group of the rebel adolescent community. As Meltzer commented:

> 'It seems that the heterosexual adolescent group has two functions: the first is to create a space in the adult world in which the adolescent can be free, the second is that in this space he has the chance of experimenting with human relations… it is very important for the adolescent that this space has a concrete existence in the world and that adults are kept outside it. For example, it is extremely important that in the family home parents keep "outside" their child's room.'

Waddell (2018) also observed that the containing function of the family disappears in adolescence, and it has to be replaced externally, and eventually internally, in the personality. She commented that:

> 'the adolescent group may be seen as performing a second-skin holding function…The group, in other words, may be performing, to

> draw on Bion (1970), a positive "exo-skeletal" function as an alternative to the holding function of the family until the endoskeleton, or internal backbone, is more firmly in place.'

Meltzer pointed out the change in adolescents' relationship with their parents, commenting that;

> 'Seen from the point of view of the adolescent, the adult world appears above all like a political structure and a class system: adults are experienced as though they had power and control of the world.'

Then, mistrust and hostility toward adults develop as they regard them as owning an aristocratic organisation with the main aim of preserving their power. Therefore, adults seem to be frauds and hypocrites to adolescents, who possess something the latter never had the right to own.

Waddell suggests that, especially during adolescence, people assert superiority, find fault with everything, or hate a 'new development in the personality as if the new development were a rival to be destroyed'. This can become what Bion described as un-learning or pseudo maturity in adolescence due to envy and hostility toward adults.

2.3.4 Clinical applications of the attachment theory

As)Bowlby (1988) observed when discussing clinical applications of the attachment theory:

> "An interruption to therapy probably always generates some reaction in a patient; sometimes it is conscious, at others unconscious, but nonetheless evident. When conscious, it may take the form of overt complaint or angry protest; when unconscious it may manifest itself by the patient disparaging therapy or missing a session or two before the break… should a patient react to an interruption by disparaging therapy or missing a session, a therapist who adopts attachment theory would ask himself why his patient is afraid to express his feelings openly and what his childhood experiences may have been to account for his distrust."

While the aim of this study is not to classify individual cases' attachment styles based on session recordings, research of the attachment theory nevertheless merits careful consideration. The results of Slade's meta-analysis (2016) revealed that adult patients who scored high in attachment anxiety showed the least remission of symptoms, while patients who rated high in attachment security had the most positive outcomes. Attachment avoidance appeared to be minimally related to treatment outcome.

The impact of attachment relationships on therapy can be conceptualised on two

distinctive levels, the first of which concerns the influence of the patient’s attachment style on the 'patient-therapist relationship'. A patient's attachment style significantly affects the quality of the working alliance and their in-therapy mode of interaction. Patients with a secure attachment style typically establish a stronger working alliance with the therapist. If patients form a secure attachment with a therapist, this capacity allows for the emergence of intense, even negative, transference, because they feel sufficiently safe to express these feelings. Conversely, insecure attachment styles generally predict a weaker therapeutic alliance. Patients with an Avoidant/Dismissing style are less inclined to seek therapeutic help, demonstrate lower compliance with treatment and engage in less self-disclosure. They report fewer relationship 'ruptures', which is likely to reflect their emotional detachment and lower level of engagement. In dialogue, they tend to minimise self-disclosure, convey an air of self-sufficiency, and downplay their own distress. With regard to the Preoccupied/Anxious type, these patients are more prone than avoidant patients to self-disclosure. They report more frequent 'ruptures' in the therapeutic relationship, reflecting interactions that are more intense and emotionally volatile. These patients exhibit a paradoxical pattern: they seek contact, but resist it. They may attempt to obstruct the therapist's interventions and express their experiences in a vague or confusing manner.

The second level concerns the impact of the therapist's attachment style, both on the

'patient' and the therapeutic process. Therapists' capacity for attachment organisation is crucial for their ability to provide a 'secure base' for the patient. Secure therapists are better able to predict their capacity to 'make therapeutic responses to the patient's individual needs', thereby establishing a stronger working alliance, in which patients more frequently perceive the therapy as helpful. In contrast, Insecure Therapists are more easily distracted by patients' defence mechanisms and may provide them with non-therapeutic responses. They tend to react to patients' 'explicit' communication rather than responding to their underlying affects and needs.

However, there is little research concerning the impact of attachment styles on therapy with a focus on adolescents. (Allen and Tan, 2016) point out that attachment undergoes a significant transformation in adolescence, as it shifts from childhood behavioural manifestations to more internalised, abstract working models. This is when adolescents move toward a 'Goal-Corrected Partnership', implying that they are no longer merely emitters of attachment behaviour; they now possess the capacity to understand and consider the goals, feelings and motivations of the attachment figure (the parent). This shifts the attachment relationship from unilateral care-seeking to a more complex, bidirectional interaction and negotiation. Furthermore, attachment functions gradually transfer to peers. Although parents remain the primary attachment figures (particularly during moments of extreme distress), adolescents begin to transfer specific attachment

functions (such as proximity seeking and the 'safe haven') to close peers or romantic partners. Secure attachment in adolescence is characterised by the ability to exhibit autonomy whilst maintaining a close bond with parents. As a result, the parents' position becomes challenging, as they are required to facilitate the adolescent's establishment of autonomy, and allow for exploration and independence.

2.4 IMPACT study

2.4.1 IMPACT study

The IMPACT study (Goodyer *et al.*, 2017) dataset is used in this dissertation. The IMPACT study is a pragmatic and superior trial in which the relative clinical effectiveness of three psychological treatments for depressed adolescents (aged 11-17 years) is compared. The three treatment arms are a Brief Psychosocial Intervention (BPI, 8 individual sessions, 4 parent/family sessions, duration of 20 weeks, undertaken mainly by psychiatrist), Cognitive Behavioural Therapy (CBT, 20 individual sessions, 4 parent/family sessions, duration of 30 weeks, mainly undertaken by clinical psychologists), and Short-Term Psychoanalytic Psychotherapy (STPP, 28 individual sessions, 7 parent/family sessions, duration of 30 weeks, mainly undertaken by child

psychotherapists). Each treatment arm is manual. Depressed adolescents are randomly assigned to the three treatment arms without an assessment for a different therapy (BPI n =155, CBT n =154, STPP n =156). Outcomes measures are taken at baseline (between June 2010 and January 2013), and at 6, 12, 36, 52, and 86 weeks after the first session. 465 participants were analysed, and 75% of them were female.

The results indicated that all three of these treatment arms can significantly improve depression and psychosocial impairments at 36 weeks (end of therapy) and at the 52-week follow-up. Although there was no significant difference between the effectiveness of the three treatment arms, when comorbidity existed, the improvement of CBT and STPP was more prompt. 25% of the patients still met the diagnosis of depression after 86 weeks.

A further analysis of the IMPACT study data indicates that depressive features and depressive cognition decreased from the baseline to 6 weeks, conduct problems decreased throughout the course of therapy and follow-ups, and the level of anxiety increased by week 6, but returned to the baseline later (Aitken *et al.*, 2020). Another finding suggested that the patients could be categorised into two groups. Therefore, 84.1% of them were categorised as ‘continued-improvers’ with symptoms reducing over time, and 15.9% were categorised as ‘halted-improvers’ with higher baseline

depression scores, faster early recovery, but no further improvement after 18 weeks. A fast reduction of depressive symptoms in the first 6 weeks of treatment may not imply a good prognosis as the halted group's depressive symptoms may increase after 18 weeks of treatment (Davies *et al.*, 2020).

Dropout was defined as the end of therapy without the mutual agreement of the therapist and the patient, regardless of the number of sessions attended, as reported by the therapist. The overall dropout rate was 37%, and 32% for CBT, 36% for BPI, and 43% in STPP. The differences between the three treatment arms were not statistically significant. The non-starter rate was between 7-14% for the three treatment arms, and no statistically significant differences were indicated (O'Keeffe *et al.*, 2018).

2.4.2 IMPACT-ME

IMPACT-ME (My Experience (IMPACT-ME) is a series of qualitative studies in which the process of overcoming severe depression is explored as experienced by adolescents and their families when receiving psychological therapies. The adolescents' causal beliefs of depression were explored in one study and they identified three types of causal beliefs: bewilderment about why they were depressed (e.g. it just happened), depression as a result of rejection, victimisation, and stress (e.g. academic stress, feeling rejected or hurt in relationships, or being bullied), and something inside is to blame (e.g.

I made too big a deal of it and now it's like a snowball) (Midgley *et al.*, 2017). The experience of being the parent of an adolescent referred to mental health services was explored in another study, and four main themes were identified: parents' 'lack of awareness' that their child was depressed (e.g. feeling confused or not noticing any changes in their child), the 'emotional turmoil' that parents were experiencing alongside that of their child (e.g. upset and distressed, guilt and self-blame, appalled and frustrated); parents' feelings of 'helplessness' (e.g. dealing with the unknown, a communication breakdown, competing demands of themselves or siblings, lack of support); and 'parenting in overdrive' (e.g. providing extra parenting for the depressed child, impact on the family, walking on eggshells) (Stapley, Midgley and Target, 2015).

2.5 Summary and Reflection

According to the literature review, patients' non-attendance is common during the course of therapy. Dropout from therapy is not uncommon, and it may not indicate a poor prognosis; it may just be that patients have got what they wanted from the therapy, or that they are receiving therapy elsewhere. However, the literature reviewed does not imply that non-attendance and dropout are unimportant; on the contrary, non-attendance and dropout are important issues that need further exploration, especially the type of non-attendance/dropout and the meaning of them from many perspectives. The richness

of these issues inspires more directions for future research, e.g. whether missed sessions are indicators of some patients' dropout? If yes, how to identify this type of missed session, and what kind of strategies can be helpful inside and outside the therapy room? Is dropout a kind of state? Is it an emotional state, a developmental state, a relational state with the therapist or with adults in general, or it is even a state related to some kinds of characteristics? Or is the research of the therapist's effect on non-attendance and dropout more to do with the therapist, or is it indicating that the relationship between the patient and the therapist is not a good match?

Chapter 3 Methodology

3.1 Aim

A thematic analysis is applied in this study in order to explore the reunion sessions (first sessions attended) after missed sessions (due to patients' non-attendance) in STPP from the IMPACT study dataset. The definition of dropout in the IMPACT study is ending treatment without the therapist's agreement. As for dropouts, they miss or decide not to attend their sessions after a certain point, i.e. their final attended session. According to O'Keeffe *et al.* (2019),

> 'dissatisfied dropouts were critical of the therapy they received and described various things about the therapy they did not like or find helpful, such as the therapists' approach to therapy, and issues regarding their relationship with their therapist. They reported stopping therapy because they did not feel they were benefitting from it.'

Compared to well-engaged completers, dissatisfied dropouts are quite a concern as they do not return to their therapy after a certain point of time, are critical of the therapy, and do not find it beneficial. It is worth bearing in mind that their study was based on interviews after the treatment ended; therefore, what dissatisfied dropouts were like in

the sessions they attended, whether they engaged in the therapy, what their relationship with their therapist was like, are issues that remain unknown. Although the construct of a reunion session has not been developed, and the aim of this study is not to develop it, a reunion session is chosen as a subject of this study. Despite not been developed or validated by research, my concept of dropouts is that they stop attending their therapy at a certain point. Conceptually, I regard dropouts as a never coming back type of non-attendance in that they knew that their therapy had not finished, and the door remained open to them, and it may be even the case that their therapists were waiting for them to return. Conceptually, I regard reunion sessions as points where they were still willing, maybe with some ambivalence, to attend/come back to therapy right after missing some sessions. The reason for emphasising the first attended session (reunion) is because I wonder if it was a kind of conjunction between the experience of non-attendance and the experience of attendance. I think that the sessions attended after reunion sessions must be meaningful to some extent too, as they were also points at which the dropouts were still willing to attend.

Bearing in mind that the construct of a reunion session has not been developed, the aim of this study is not to develop it, nor to address the importance of reunion sessions for dropouts. With my keen wish to better understand the dissatisfied group, and myself as a single researcher doing this study as my doctoral dissertation, the aim is an attempt to

understand dissatisfied dropouts through an entry point that I believe might be meaningful and can make this study doable; therefore, the entry point I have chosen is reunion sessions.

3.2 Design

In the IMPACT study, 465 adolescents with moderate to severe depression received CBT, STPP, and BPI were included in the analysis. The therapy sessions were audio recorded. IMPACT-ME is based on the participants of North London Centre branch of the IMPACT study. The sample size of the IMPACT-ME study was 127 adolescents, 67 of whom were categorised as completers, 7 as non-starters, and 53 as dropouts. Of the 32 dropouts included in the study of O'Keeffe *et al.* (2019), 9 were in CBT, 14 in STPP, and 9 in BPI. 18 of them were categorised as dissatisfied dropouts, 3 of whom were in CBT, 12 in STPP, and 3 in BPI.

The design of this study is based on the dataset of the IMPACT study. The sample pool is based on dissatisfied dropouts categorised in O'Keeffe's study (2019); therefore, there were 12 patients of STPP in my initial data pool. After the data selection process, the selected audio recordings were subjected to a thematic analysis.

3.3 Data selection

The initial data pool is 12 patients categorised as dissatisfied dropouts. Initially, the plan was to select six dissatisfied dropouts, and one reunion session for each of them. The dataset from O'Keeffe *et al.* (2019) included the patients' basic information: age at baseline, gender, and ethnicity; and attendance information in terms of which sessions were missed. Missed sessions were defined as sessions that had been scheduled, but that the young person neither cancelled in advance nor attended, as recorded by the therapist.

The dissatisfied dropouts were selected if they had at least one reunion session that met the following two criteria: (1) it was not the final session attended by the patient. (2) it was not in the early stage of treatment, i.e. the first six sessions since treatment began. The rationale to exclude a reunion session as the final session attended was because the aim of this study is not to explore the point where patients decided not to attend therapy anymore. The rationale to exclude a reunion session from the first 6 weeks of treatment was because, according to Davies *et al.* (2020), a fast reduction of depressive symptoms in the first 6 weeks may not imply a good prognosis, but only that there is a trend for the participants' depressive symptoms to reduce in the first 6 weeks. 6 out of 12 dissatisfied dropouts met the above criteria. However, only one reunion session of one patient was not an ordinary psychotherapy session; hence, it was suspended, and a psychiatrist was invited to join the meeting for the purposes of risk management.

Therefore, only five reunion sessions, one from each of 5 dissatisfied dropouts, were included in this research.

3.4 Data analysis procedures

As this study is an attempt to understand dissatisfied dropouts' in-therapy experience by audio recording the reunion sessions, the aim is to identify themes and describe the dataset in a meaningful way. Therefore, as Braun and Clarke (2006) suggested,

> 'a thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail.'

Hence, a thematic analysis was chosen to be conducted in this study and the analytical procedures follow Braun & Clarke's (2006) six stages of thematic analysis, which are summarised as follows;

Phase 1: familiarise yourself with your data

As I was not collecting the data myself and I am not a native English speaker, this stage was important to me. As Braun & Clarke (2006) suggested,

> 'it is vital that you immerse yourself in the data to the extent that you are familiar

> with the depth and breadth of the content. Immersion usually involves 'repeated reading' of the data, and reading the data in an *active* way - searching for meanings, patterns and so on. It is ideal to read through the entire data set at least once before you begin your coding, as ideas and identification of possible patterns will be shaped as you read through.'

Because the audio recordings of the sessions selected had not been transcribed when I had access to them, transcribing them was the first analytical procedure. As Braun & Clarke (2006) mentioned, transcribing is a time-consuming process. There were times that I found it boring and frustrating, but I would describe it as a privilege to be able to observe clinical encounters in a third person position and pay attention to the patient's talking and feelings conveyed via sounds, like the therapist. Although it was not video recordings, the material was still very rich and could trigger powerful feelings in me. After transcribing the data, I read and re-read the transcripts and started to take notes or mark ideas for coding, as Braun & Clarke (2006) advised.

Phase 2: generating initial codes

Apart from the notes I was taking, I started 'generating an initial list of ideas about what is in the data and what is interesting about them'.[2] As a child psychotherapist,

[2] From phase 2 to phase 5, if I use quotation marks without referencing other authors, it means

I had lots of psychoanalytically-informed associations while generating the codes. I was then advised by my research supervisor, Jocelyn Catty, that I could write them in another notebook in order leave them aside during the analytical process, and return to them in the discussion section, if appropriate. Hence, the findings presented in the next section do not include the codes and thoughts from the notebook, i.e. the more psychoanalytically-informed thoughts.

With regard to the reflection suggested by Braun & Clarke (2006) of whether the themes are more data-driven or theory-driven, I approached the data with the question in mind about what the reunion sessions were like for dissatisfied dropouts. Although it is more of a general question than a specific theory-orientated one, there are quite a few assumptions about the background that would have some impact on the analytical procedure. For example, as my focus is dissatisfied dropouts, given that the patients were adolescents with moderate to severe depression, I may not focus much on the themes regarding depression, because that was the inclusion criterion for all the patients who participated in the IMPACT study, unless there were special qualities in repeated patterns. Moreover, the knowledge of those patients dropping out later in their therapy and being categorised as dissatisfied dropouts after the

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that I am citing Braun & Clarke's (2006) paper on thematic analysis.

treatment ended would be likely to influence the analytical process to some extent.

Although my research question is quite general, I was inclined to regard the themes as being theory-driven. Therefore, I followed the advice of Braun & Clarke (2006) for this phase:

> (a) code for as many potential themes/patterns as possible; (b) code extracts of data inclusively; and (c) remember that you can code individual extracts of data in as many different 'themes'

In this phase, my analysis was conducted electronically; therefore, I borrowed a big screen, only for research purposes, so that the data, codes, and highlights could be presented as much as possible at once during the analysis.

Phase 3: searching for themes

In this phase, an attempt was made for the analysis to be of the broader level of themes, which 'involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes.' Different combinations of codes to form themes were explored, and this process was repeated several times in order to obtain several thematic maps for comparison. Thematic maps were drawn on the IBM SPSS Amos software, which was originally used for

structural equation modelling (SEM), because it is easy to use for drawing thematic maps and it is available on the university of Essex website. I ended this phase when a collection of candidate themes and sub-themes and some potential thematic maps were completed.

Phase 4: reviewing themes

Many of the themes in the previous phase were refined. Some of them were combined with others, and some of them reorganised. I then followed the procedures of 'two levels of reviewing and refining'.

Level one: 'reviewing at the level of the coded data extracts.' Re-read the collated extracts for each theme, and examine whether the pattern is coherent. Then 'rework your theme, creating a new theme, finding a home for those extracts that do not currently work in an already-existing theme, or discarding them'. New candidates of thematic maps were developed on this basis.

Level two: 'a similar process, but in relation to the entire dataset.' The validity of each theme in relation to the dataset and the accuracy of the representation of meanings of the thematic map were examined, but also whether the candidate thematic map 'accurately' reflected the meanings evident in the dataset as a whole.

In this phase, I decided to discard two themes from the analysis. One was aggression, e.g. one enjoys punching others, or one enjoys watching others being attacked. This theme was decarded, because as Waddell (2002) suggests,

> 'The rising levels of sexual and growth hormones lead not only to the development of sexual organs and secondary sexual characteristics, but also to greatly increased, though highly variable, sexual and aggressive drives, often with powerful accompanying fantasies.'

Aggression is a common issue for adolescents, and more than half of the occasions on which those patients talked about it were with quite a light tone rather than feeling very angry or needing an outlet for strong feelings. The other theme I discarded was sadness. The reason it was discarded was because all the participants of the IMPACT study were diagnosed with depression; hence, I assumed that it was not only common in the selected patients, and that I would find the themes that may represent the reasons for sadness or related to sadness to be more meaningful.

Phase 5: defining and naming themes

'Define and further refine the themes you will present for your analysis, and analyse the data within them.' Attempts were made to identify the essence of each theme and

the essence of overall themes, and ‘determining what aspect of the data each theme captures.’ The themes and subthemes were organised with the selected examples of representative extracts. Moreover, the extent to which the themes overlapped was examined. How the themes and subthemes related to one another will be discussed in the discussion section.

Phase 6: producing the report

The findings were written up in the next section with representative extracts that captured the essence of themes and subthemes.

3.5 Ethical considerations

The ethical approval of this study was granted as part of the ethics for the IMPACT study. Confidentiality was maintained as strictly as possible, and all the names in the material (patients’, therapists’, or anyone’s names, and identifiable places) were all anonymous. The audio recordings were encrypted, and portable storage devices were encrypted by the Tavistock Centre as part of the student services.

Access to the IMPACT data by Tavistock & Portman doctoral students is covered by the ethical agreement between the trial and the National Research Ethics Service (NRES Committee East of England – Cambridge Central) was approved on the 1st of

May 2020.

Chapter 4 Findings

Information about the patients and therapists is summarised in Table 1, and information about reunion sessions and attendance is summarised in Table 2.

Table 1: Information about patients and therapists

Patients' name[1]	Patients' gender	Patients' age (years)	Therapists' gender[2]
Andy	Male	17.0	Female
Bella	Female	14.4	Male
Ched	Male	17.3	Female
Debby	Female	17.0	Male
Emily	Female	17.8	Female

[1] All the patients' names are pseudonyms.

2 Andy and Ched had the same therapist; Bella and Debby had the same therapist.

Table 2: Information about reunion sessions and attendance

Patients' name	Reunion session number	Attendance before reunion[1]	Gap before reunion[2]	Next attended session[3]	Final attended session[4]	Overall attended sessions
Andy	18	7	4	23	23	9
Bella	14	7	2	15	15	9
Ched	11	4	3	12	15	8
Debby	11	8	2	12	15	9
Emily	13	9	1	-[5]	19	-

[1] How many non-missed sessions were before the reunion session.

[2] How many consecutive sessions were missed right before the reunion session.

[3] The next session attended after the reunion session.

[4] The final session attended in the STPP course.

[5] - means unknown due to missing data

Four main themes were identified: “Absence and reunion”, “Sense of helplessness”, “Turning to peers”, and “Signs of withdrawal”. The main themes and subthemes are summarised in Table 5. These themes and the subthemes under each of them are described below, and some materials are quoted as examples.

As only five sessions were analysed, instead of presenting condensed material as examples, some detailed material is presented in order to demonstrate that the themes and subthemes identified are, to a large extent, very simplified, and that the material itself is much richer than this study attempts to present.

Table 3: Main themes and subthemes

Main themes	Subthemes
1 Absence and reunion	1-1 Explanations for the absence 1-2 Feelings during the missed weeks 1-3 Locating the current session within the course of therapy 1-4 Difficulties and ambivalence toward attending therapy
2 Sense of helplessness	2-1 Disturbing situation 2-2 Lack of hope toward changes 2-3 Limited space for thinking and reflection
3 Turning to peers	3-1 Disappointed with parents 3-2 Protection and new life 3-3 Wish for independence
4 Signs of withdrawal	4-1 Triggers of withdrawal

	4-2 Avoiding vulnerable feelings 4-3 Withdrawal or withholding from the therapeutic relationship 4-4 Passive withdrawal 4-5 Results of the withdrawal

1 Absence and reunion

This theme is focused on reuniting after an extended gap due to being absent from the reunion sessions, what the patient and the therapist discussed about the patient's absence, what coming back to the session was like, and where they were in the course of the therapy. Four common subjects were identified from this theme: explanations for the absence, feelings during the missed weeks, locating the current session within the course of therapy, and difficulties and ambivalence toward attending therapy.

1-1 Explanations for the absence

The absence of all the five patients and therapist dyads was discussed in the reunion session, and why the previous session(s) were missed, having been either brought up by the patient or queried by the therapist. At the beginning of Andy's session,

T: Hello, it's been a long time since we met. I understand a lot's happened.[3]

(silence)

[3] As the methodology of this study is not a conversation analysis, some interjections were deleted to make the transcript easier to read.

T: You must have quite a lot to tell me, no?

Andy: I don't know, probably. I left college.

T: Was that recently?

Andy: Yeah.

T: You didn't feel you wanted to.

Andy: I don't think I can handle it at the moment. I think it's best to take a break. And I want to move to ***(another city) next year.

…

T: …leaving the college, was that a big thing to make a decision about, or… not?

Andy: It was easy.

I wonder if it was quite a shock for Andy's therapist to be told that he had left college during the missed weeks, but it seems that Andy's dismissive attitude made it difficult for his therapist to explore it further when he had 'just returned' to his therapy after missing four consecutive sessions before this reunion session.

Ched's therapist brought up the fact that they had not met for a while, and they discussed why he had missed the three previous consecutive sessions, two of which had been missed due to school-related reasons (exams and revision) and the other due to feeling unwell.

Debby and Emily also referred to practical reasons. For Debby, it was due to having to attend a university affair, while Emily had to attend a funeral. They both apologised for missing previous sessions, and the reasons for missing them was the first thing they brought up in the reunion sessions.

1-2 Feelings during the missed weeks

Compared to the reasons the patients offered as to why they had missed the sessions, for some patients, their feelings or mood during the missed weeks seemed to be more meaningful than the reasons themselves. For instance, at the beginning of Debby's session,

Debby: I'm sorry about the last couple of weeks (two consecutive missed sessions)... I know I should have called, but Thursday I had a university fair thing I was going to do. And the Thursday before that, it was half term, so I just slept. I didn't wake up.

…

T: So, you mean that you were at a university fair all day last week?

Debby: Yeah, the week before, it was half term and I didn't leave my house for like five days.

T: Why?

Debby: I don't know, like... The start of the half term was really good. I went out with my mates…And then I was supposed to go out with my friends Wednesday night. But I didn't, so I just stayed at home. And then I didn't leave my house until Monday. After that, I just stayed at home…I was just like not in the mood to leave the house.

It was revealed in the following discussion that Debby had been stuck in a withdrawn state of mind, having been let down by her friends for a meet-up that she had looked forward to.

1-3 Locating the current session within the course of therapy

Four of the five therapists referred to which session it was within the time-frame of the course of the therapy. Some of the patients seemed to have little awareness of which session it was and how many sessions were left. Moreover, some of them appeared to have misunderstood the rescheduling policies, and some of them assumed that it was not possible to reschedule, even for good reasons.

Explaining which session it was and how many sessions were left seemed to provide an anchor for the patient and the therapist to locate were they were in the course of the therapy, and it also seemed to enable the patient to be aware that the therapy was time-

limited.

As for Andy, after the discussion about loss and stealing (losing the income support money and then stealing food from a supermarket), he began to text his friend(s) and became more distant from his therapist, who talked about Andy's absence and which session it was.

T: Because we've known each other for a while, although you haven't kind of come to many of your sessions, I was looking a bit before you came to just kind of see where we are with the whole process because we said we would have something like twenty eight sessions, and I've counted seventeen up to now.

Andy: Do you know when I'm next having a ***(name) session?

T: I don't know. How many of those have you had?

Andy: About three…Every time I go to them (the *** sessions), things seem to have gotten worse.

When Andy's therapist referred to sessions being missed in a gentle way (10 sessions missed out of 18) and where they were in the STTP course, instead of responding directly, Andy talked about another type of appointments, and how he felt worse when he attended them.

Bella’s therapist brought up the session’s location in the STTP course, and made links to the previous break and her difficult relationship with her father and how hard it was for her to acknowledge what wasn’t there (the absent parental figure). The therapist worked on her absence tightly with the transference. Emily’s therapist also linked the missed sessions to the previous break, which made it difficult for Emily to attend her sessions.

Ched’s therapist located the session in the STTP course, while Ched talked about the social difficulties he struggled with and his helplessness. While locating the current session in the STPP course, Ched’s therapist talked about the patient’s assumption that sessions cannot be rescheduled, as if there was no flexibility, and he regarded the therapist as having rigid rules.

Debby assumed that she could not rearrange her therapy sessions.

Debby: I know I can't rearrange the appointments, like if I miss one, I miss one.

T: What do you mean you can't rearrange them?

Debby: Like you said, if I don't come, then it's like, it counts as one anyway, because that's…

T: That's true, but it's not the same as rearranging an appointment. It's not as if you ring up and say, I can't come on Thursday, could I come another time. Or I can't

come through Thursday.

Debby: Oh, okay. I just assumed…

T: But you have rung me before, haven't you?... Maybe you felt, oh, but he's so strict, he's not going to be able to tell me anything more. Now your picture of me was as this harsh person who really stuck by the rules and these are the rules and that was it.

The exploration of the therapists being strict or not flexible often followed the issue of how patients perceived the cancellation and rescheduling rules

Emily thought that no replacement session would be given for any reasons. Her therapist clarified with her that she missed the previous session for a funeral, it was a reasonable reason, so a replacement session could be offered if she gave notice in advance.

1-4 Difficulties and ambivalence toward attending therapy

There was much ambivalence toward attending therapy in four out of five patients' sessions. This may have been presented in different ways. It may have been explored by the therapists, or may have been obvious from patients' ambivalent behaviour. When the therapists explored patients' ambivalence toward attending therapy, they often

discussed patients' potential difficulties in attending the sessions as well. For example, right after Andy had said that the decision to leave college was easy,

T: I noticed that you sent an email last week in which you said you wouldn't come, but you are here today. So, perhaps you are kind of coming in a different state of mind.

Andy: Nah, I just walked here.

Andy remained silent for a large proportion of the session, and there were times that he focused on texting his friend(s) rather than talking to his therapist. This pattern of cancelling in advance, but showing up to the session, being dismissive/withdrawn in the session, seemed to represent his ambivalence toward attending the therapy.

When Bella complained about her father not caring about her, the therapist linked Bella's absence to the previous break and commented that (coming) here (the clinic) is somewhere where she can come to talk about these things, but it is her that comes. He doesn't come to her.

T: I wondered if it might have had something to do with us having had a Christmas break. And here is somewhere where you can come to talk about these things but it is you that comes. I don't come to you. And you feel that your dad, well, you have to go to your dad first. He doesn't come to you.

Bella: Not even that. If I don't ring my dad, like he'll moan at me for not ringing him…You (dad) have loads of minutes. You don't really ring people, what's so harmful about ringing me? It's not going to kill him.

T: And of course I send letters when…

Bella: You send me more letters than my dad calls me, way more than my dad calls me.

T: But maybe that feels a bit more like a moan. As if I'm saying why haven't you come, Bella.

Bella: Well, yeah, in a way it does. When I read it, I'm just like, "Oh, I forgot it." I've got so much of my own stuff in my head at the moment. I keep forgetting things.

Bella's therapist linked her non-attendance to her relationship with her father, which she enacted in the transference.

Ched's therapist linked his absence with his sense of helplessness.

T: I wonder if you're also feeling like that about the therapy… I've found that this is supposed to be session 11, although we've actually only met four times…That is a fact… Perhaps you have mixed feelings about the therapy…like what's the point if nothing's going to change?

Ched: No, I don't think so. I think a lot of it is that I've just been unlucky with things. It's not like I've decided not to come. It's just that I wasn't able to.

T: …somewhere you may feel that, um, the therapy's not going to change anything any time soon, that kind of thing… I wonder if you feel discouraged, you know, in that sense.

Ched: A bit, I'd say.

Debby's ambivalence toward therapy had a layer that was different from that of other patients, as her parents were involved in this dynamic.

Debby: …my stepdad really wants me to stop (therapy)… Mum asked me yesterday. So did you call and say you're not going anymore? And I was like, no, no, no. I'm going to go tomorrow and see whatever happens. And that was it. So I was kind of brushing it to the side at the moment. Like, not talking to her about it.

T: …There's a side of you who, who sides with your stepdad and your mum, you know, part of you like goes, no, no, you don't want to come, don't be stupid, it's rubbish, what's the point. And another part of you that says, oh yeah, I would quite like to come, and you know, whether they kind of don't join up very much, actually.

It must be quite difficult for an adolescent to attend therapy without her parents' support. Apart from the external pressure, her therapist made a link to her ambivalence toward

therapy later in the session.

T: I was also curious about why did you come back then today.

Debby: I think it was a mix between I felt kind of bad for not turning up and not calling, and I don't know I feel kind of like awesome for the last two weeks, but I'm worried if I stop coming completely it will be some weird anomaly in my timeline of black holeness… I noticed I was feeling quite like good last time I came. Then during the half term I had a couple of bad days, hence not leaving the house for five days, and then I went to school.

T: …so actually there was a period of time you missed the session, you weren't feeling good, the, the first one you missed during half term. You were actually feeling pretty miserable.

There was a sense of a state of mind in which she either felt good, trying to manage things on her own, or she was overwhelmed by feelings of rejection and was stuck in isolation.

2 Sense of helplessness

The second theme is focused on an effect that is common in some cases: a sense of helplessness, which is mainly expressed by disturbing situations, a lack of hope that

things will change, and limited space for thinking and reflection.

2-1 Disturbing situations

Some patients talked about some very disturbing feelings they had encountered, which gave the therapists cause for a great deal of concern, whether the patients themselves were as concerned as the therapists or not. Different types of disturbing feelings were described: due to an abusive friend (Andy), physical safety under threat (Bella), and social difficulties that the patient had struggled with for a long time (Ched).

Andy talked about a disturbing situation:

Andy: There was someone in my life who used to make it a living hell. But now they're gone and I don't know, I'm just trying to get over it.

T: Hm, what, what happened?

Andy: They just messed with my mind. I mean…They just played games with my head and hurt me.

T: Hm, well, that would be important to hear about, something painful.

T: But I haven't heard about that before, you've never told me about somebody who was playing games…and they hurt you.

T: What happened?

Andy: Lots, (they) used to do things like cut themselves in front of me, cut themselves and blame me. Take loads of pills and tell them that I told them to do it. Mess with my head.… Force me to give an answer that would hurt them or me. There was no way of winning.

T: Now I'm not sure whether you're talking about a person who's doing that to you because you never told me that before, when we did meet.

Andy: I wasn't aware of what was going on.

Andy added later that the relationship with this abusive friend lasted for eight months. There were other things that Andy talked about that were also very concerning. For instance, 'I ran up the phone bill to about £300', and after losing the money of income support shortly after getting it, he stole food three times a day.

Bella and her female friend, B, were in quite a disturbing situation.

Bella: This is a serious matter (a boy threatened to kill her and B) but we're not bothered…It's a messed-up world…What's the worst that can happen? Like okay, they're threatening to kill us, but we're not scared…But obviously B was a bit paranoid, as you can see she's still got her hood up. But I'm not… I can't be bothered…I don't need people praying for me. I know I'm not a happy child…I can't be happy. I can't put on a fake smile for no reason... but at the end of the day,

> if I did get killed, to be honest I'd be in a far better place than this world is…This world's sick, I hate this world…I'm sick of this world.

Bella conveyed a strong sense of helplessness. However, it was not clear whether her view of the world was very pessimistic due to the threat, or whether it had already been very pessimistic, even before the threat.

Ched struggled with social difficulties at school, which seemed to have contributed to him not attending school previously. When Ched talked about missing a lot of school and how it may result in a poor academic performance, he commented that, '(he was trying to accept) just the fact that the way things (social difficulties) are now must be how they're going to be for quite a while.' This conveyed his sense of helplessness, which had maybe lasted for a long time.

2-2 Lack of hope that things would change

Whether the patients were struggling with disturbing feelings/situations or chronic difficulties, some of them represented a lack of hope that things would change, so there was a sense of being stuck in their mind.

Trapped in the difficult situations mentioned above, the patients did not seem to feel that there could be a way out, or someone that could make things different. Therefore,

they felt they just had to bear it, and let the days pass. However, it was a question of whether the difficult situations were really the whole picture or whether there were other perspectives or reasons that had made their situation more difficult. Andy's therapist talked about him being withdrawn and sad when he remained silent for quite some time in the second half of his session.

Andy: I just want to get out of London. I feel terrible in London. I feel good in *** (another city where his friend lives).

T: It must feel good in some ways to have something that you…

Andy: It does, whether or not I have depression, paranoia, and I feel depressed most of the time… (his abusive friends) are out of my life. Let's see, things are better there.

In terms of the difficulties in struggling with college, financial issues, abusive parents (in the past, it is not clear whether this is still happening), the abusive friend, moving to another city seemed not to just imply that things are better there, but that things are really difficult here, and leaving may imply that there was little hope for things to be different here.

While Ched talked about his expectation that his social difficulties at school were not going to change in the near future. he recalled a dream he had had.

Ched: I had a dream about creating a business, and I was going around looking at different places where I could set it up…it was sort of like a venue where... it's like loads of... where people go to, like, play each other at, like, I don't know, video games…I went up to a lot of people and asked them about it. And they said it was a really good idea. And I was like, loads of people helped me do it because they thought it was a good idea.

The dream seemed to imply his wish for social interaction, and his plan for summer was discussed.

T: Have you got any plans for the summer?

Ched: No. It's just that we'll mostly be inside my house again.

T: You'll just be inside? [Yeah.] And does that bother you?

Ched: Yeah, I mean, if I had the chance, I would go out nearly every day but I don't. Because I don't have anyone to go out with.

T: Do you think you really would though? [Yeah] Or do you quite like staying at home?

Ched: No, if someone asked me to go out, I would go out, but I don't really have the opportunity, so I'm just staying inside.

…

T: Couldn't you do some things that might help your mum for example?

Ched: I do…like over the past few days. Because I've been so bored inside the house. I've cleared out all the front garden now… It's because I wanted to get out and I wanted to actually get some sun rather than being stuck in whilst it's very sunny…I don't want to be inside doing nothing every day.

Although Ched managed to find something to do so that he was not 'stuck in' having nothing to do, there was a sense that he was and would be 'stuck in', having been being socially isolated during the upcoming summer break.

2-3 Limited space for thinking and reflection

Some patients allowed very limited space for the therapist to explore possibilities for change or for getting help. In an extreme case, for example, Andy did not tell his therapist about the unhealthy relationship with those friends until they were no longer in touch. Therefore, he missed the opportunity for this experience to be thought about while it lasted.

In some cases, although the therapist's attempts to explore were not quite supported, or even welcomed by the patient, it seemed to the therapist that there may be issues around the patient's tendency to say no to the possibilities of change or to some extent, part of

the reasons why a difficult situation lasted seems to have involved the patient's choice.

For example, Bella talked about the boy threatening to harm her.

T: Does your mum know about these people?

Bella: No, but I don't want her to know. Cause then she'll be like, 'You're not going out, you're not doing this.' And just because people are after me, doesn't mean that I can't go out, doesn't mean that I can't enjoy life (...) If my mum found out, she'll tell my dad, my dad'll be like, (clap) 'You're staying round mine.' I'll be like, (clap) 'No, I'm not.' (clap) The boy lives there, sorry.

It seemed that, although Bella's safety was threatened by the boy, there were other priorities that were even more important to her than her physical safety, or she had no confidence in her parents as protective figures, so she would rather cope with it on her own, and she did not want to be asked to stay in for the sake of protection.

Bella: (when talking about the boy who threated her asking her to come and meet him) Come on man, stop being stupid. We need to learn the hard way.

…

T: You feel like you're under attack and you really need me to know that today.

Bella: I don't feel like I'm personally under attack. I feel like this world's just got sicker and sicker. I know some people who won't even step a foot outside their

door. I know some people who have dropped out of school cause they're in so much trouble they don't want to step a foot outside their door cause they're scared they're going to die… (a friend of hers) He said, 'I'm never setting foot outside this door again.' So how do I know he hasn't hurt himself.

T: Well, how do you?

Bella: I don't.

T: But I think that all of these things are terribly sad.

Bella: They are, but it's complicated. Like, you just have to learn the ways of the world.

This might be another reason why she did not want adults to intervene even when she was threatened. There seemed to be, at least a part of her, that wanted to learn the lesson by herself, or wanted a sense of agency more than protection from the carer.

When Ched's therapist explored where he could go to find someone who shared the same interests as him during the summer break.

Ched: I don't see anywhere I could go to achieve that. There aren't any activities or workshops…

T: You say no very quickly without even thinking about it, but it's very hard to imagine there is nothing that you could take up over the summer that would have

any potential to feed your interests.

Previously in the session, Ched had said he found going to school exhausting and tiring.

T: What's taking up the energy?

Ched: Because when I do go to school and I'm talking to people and I'm constantly mindful of my surroundings and I'm constantly evaluating what I'm doing.

It seems that Ched not only struggled with having no friends to talk to at school, and feeling helpless about it, but he also struggled with being too self-aware when he is in social situations. Therefore, although he wanted to socially interact with people, socialising could be quite anxiety provoking too.

This subtheme identifies a situation in which some patients had limited space for thinking and reflection, even in difficult scenarios. It seemed as if different reasons contributed to this, it may not just have been the patient's reluctance or resistance to thinking and reflecting.

3 Turning to peers

This theme is focused on patients' tendency to turn to peers because they wanted to reduce contact with their parents due to being disappointed with them, or they were

looking for something positive from their peers, such as protection, a new life, or independence.

3-1 Disappointed with parents

Some patients did not find their parents supportive or caring. When this was the case, turning away from their parents due to disappointment and, as a result, turning to their peers, seemed to be why they became attached to them.

Andy only mentioned his parents once in the session, when he said that ‘My parents used to let me shop lift’. Although he did not elaborate this in this session, it is very likely that he was, or had been, quite disappointed with his parents for some reason.

Bella complained quite a lot about her family, especially her parents.

> Bella: I’m not getting on with my mum no more…My dad doesn’t even talk to me…You’re meant to be the adult, so what about you start caring (for Bella)? Cause I can’t do all of it, I’m only 14. I’ve got too much stuff on my plate already...I don’t even feel like I have a dad. And he doesn’t bother me either. For me it just feels stupid calling him ‘dad’. It’s pathetic.

Bella’s disappointment with her parents seemed to relate to her turning to her friend, B.

Bella: The only person I can turn around and say something to if I'm worried is her (B), and she'll stand there and she'll listen and she'll help me. My mum can't do that, she'll just be like, 'Well, it's your own fault. Well, you should have done this, well, you should…' I'm asking you for help, I'm not asking you to have a go at me... Whereas B, if I turned round and said to her… she'll sit there... she'll ask me to tell her, I'll tell her and then she'll help me. But I can't do that with my mum. I can't even tell my mum family problems. I still go to B for family problems.

T: I'd like to think a bit more about your relationship with her (B) really, because she seems to fill a very important role in your life. Probably more than one role.

The therapist then explored Bella's disappointment with her father .

T: Talking about that (Bella's struggle with B being a couple with someone else) reminds me about when you tried to strangle yourself…That was after your dad had…

Bella: My dad had hurt me.

T: But he'd hurt you because he'd taken somebody else's side, hadn't he? You were supposed to stay with him and he'd said…

Bella: He told me to go home…because his sister didn't want me there.

Later in the session, there was a discussion of the lack of a caring and protecting figure.

T: Who's looking after you?

Bella: Me, myself, I can't, you can't really, Well, basically, it's complicated. I'm looking after myself, but while I'm watching my back, I'm watching B's and B's watching mine. She's like, she's like my shield and I'm like hers.

It is not clear whether there is a direct causal relationship between turning away from parents and turning to peers, but to some extent, turning away from parents may make some needs unmet, which makes turning to peers more appealing.

Debby briefly talked about her disappointment with her mother in the way that she wanted her mother to attend a GP appointment with her, but she was unable to let her mother know. She then attended the GP appointment by herself, and felt dissatisfied. She also complained that when she raised funding for her project, she did not feel that her parents had supported her.

3-2 Protection and new life

Given the above reason, when they encountered difficulties or threats, they turned to their peers rather than parents/family for protection, or they even wished they had a new life with a friend away from their hometown.

Andy wanted to move to another city where his friend lived, and 'things are better there'.

He seemed to wish that moving to another city and turning to his friend would bring him a new life which would be better than his current life, which had lots of difficulties.

As mentioned earlier, one of the reasons Bella and her friend, B, were together almost every day was their need for protection (watching each other's back) as they were both under threat.

3-3 Wish for independence

Apart from turning away due to disappointment, the wish to own their autonomy or sense of agency and their wish for independence were other reasons why they turned to their peers rather than turning to adults.

Betty said she did not want her mother to know that the boy had threated to kill her and B, because if she knew, she would not allow Betty to go out, and she did not want to be stopped going out or enjoying her life, even it was for protective reasons.

Emily said that she enjoyed her driving lessons, and she had better control of the car than she had imagined. She liked the independence of being in the driving seat, and she wanted to go on a road trip with her friends to different parts of the country.

4 Signs of withdrawal

It was often mentioned in these cases that the patient showed some signs of withdrawal in terms of missed school a lot/stopped attending school or staying at home for several days. Apart from this kind of avoidance, there were emotionally-based, relationship based types of withdrawal, and another type of withdrawal which had a characteristic quality of passivity. Being in the withdrawal state for too long had some consequences and, when they were in touch with those consequences, their affect became different.

4-1 Withdrawal from school and social isolation

Triggers or reasons for withdrawal were explored when patients showed the above signs of withdrawal, e.g. depression, helplessness, feeling let down by friends, social difficulties. Andy told his therapist that he had left college as he could not handle it at the moment. When his therapist asked whether it was a big decision, he said it was easy. Then his therapist acknowledged that he hadn't been attending for very long.

As mentioned previously, due to having no friends to talk to at school and to hang out with, Ched was quite socially isolated and withdrawn. Ched missed school quite a lot due to social difficulties.

After Debby being let down by her friends because of the meet-up which she looked forward to was cancelled, she did not leave home and felt miserable for a few days.

Emily missed year 11 a lot and then suffered from not being able to be in the same class with her friends due to grade retention. As those details are presented in other sections, only summaries are presented in this subtheme.

4-2 Avoiding vulnerable feelings

When the triggers or reasons for withdrawal were explored, many of these patients intimated that it was difficult to explore their feelings of distress, e.g. ‘I don’t care’, ‘I am not bothered’. It seemed that, when they showed signs of withdrawal, they also developed some kind of difficulty with being helped.

What often followed the therapist’s attempt to explore the difficulties related to withdrawal or the vulnerable feelings behind it, was the patient’s silence or resistance to the exploration. For instance, Andy talked about losing money and then stealing food.

Andy: I got £30 (income support) from my social worker yesterday, but I lost it, and then… I lost it in like fifteen minutes somehow, so I went to *** (a supermarket) and I stole a lot of food…Three times in one day.

T: Because you didn’t have any money to pay for it?

Andy: Probably, better though than I would have if I could have afforded it… losing the money didn’t bother me because it wasn’t money I had in the first place,

so it wasn't really mine to lose. It made the day more interesting.

T: This is interesting because the loss doesn't seem like a loss, because anyhow it wasn't yours…but there is this kind of feeling like there is nothing to lose then if you don't have it, isn't there? How can you feel a loss? Because I'm suggesting that you may feel a bit kind of lost at the moment. Something's not quite right. What you were given was not yours anyhow, so it doesn't matter if you lose it, does it?

Andy seemed to tend to act out his vulnerable feelings, whether he felt lost or deprived. He used the word 'interesting' to describe his feelings that day. His therapist picked it up and elaborated the vulnerable feelings behind it.

Bella talked quite a lot about her distress and worries, e.g. her physical safety being threatened, disappointment with her parents, and feeling uncertain about whether she was pretty. However, she kept adding, 'I'm not bothered' after talking about these issues.

T: Maybe it is hard to show people the sort of weaknesses and holes…I was thinking that you had a little hole.

Although Bella kept emphasising that she was not bothered and she was not scared, it was clear that she was avoiding being in touch with her fear.

Bella: I could never be scared. Like, sometimes, yeah, I'm scared of like, I'm scared of my dad. But if I, if I, if I grabbed a shield and put it in front of me, my dad would have less armour. I would have more armour against him than he's got over me. That's what you need, you need more armour. I've got a shield in front of me. Wherever I go there's always going to be a shield in front of me and I'm not going to show my fear.

Debby talked about what had happened had made her stay at home for a few days feeling miserable.

Debby: …It was from the point that… they had just cancelled (the meet-up). And like from that day on… I just felt really like crap.

T: You were very upset that they had cancelled it. You felt very rejected.

Debby: Not even rejected. It was just like they'd left it a bit late.

T: What did you, what did you feel then?

Debby: They, they'd just left it a bit late and it was like, it was more like…

T: Hurt?

Debby: No, I wasn't hurt. No, because it wasn't like I was upset. It was more like I'm annoyed.

T: Why couldn't you be upset if you wanted to see them? What would be wrong

with that?

Debby: I wasn't… I wanted to see them like, if I don't see them I'm going to miss them and be sad…I sorted out my outfit. I plaited my hair last night.

T: You'd made an effort.

Debby: Yeah, I'd made an effort… But I was more annoyed than upset. More like, it's two hours before I was supposed to leave the house.

T: So, you were really angry about it. Is that why you were punching the walls?

Debby: Yeah, I had to… (punch the) boxing bag type things that are in the shape of a man… At least I wasn't hitting the walls.

…

T: I wonder if there's something about the kind of more sad feelings that you might have that are just kind of destroyed by actually being in a rage. So you can only think about being cross, rather than actually feeling that they let you down, that they really wanted to see you or whatever… and then what happens is that you collapse and become a recluse.

The therapist explored the way in which Debby managed her sad feelings by being angry. It seemed that Debby found it difficult to bear vulnerable feelings like sadness and being let down.

Emily talked about missing the previous session because she had attended a funeral and had gone straight to bed afterward.

Emily: I don't like doing it (crying), and I don't do it in front of people. I don't mind doing it, but if I do need to cry, then I'll have to do it on my own, and it's quick, and it's over in a flash, and I'll get on with things.

T: So, maybe you were worried about coming here and being a bit vulnerable and crying?

Emily: I don't like it when other people cry. I really hate it. Because you never know what to do. I just sort of stand there and I'm just like, okay, I'll just walk away now. I don't know what to do. It's that thing, I don't know how you're meant to act when someone's crying. Of course you have to comfort them. But there's nothing you can really say when someone's crying. You can't really say it's going to be okay because normally, if you're crying, then it's not going to be okay.

…

Emily: It (physical discomfort) happened and then I forget it and it happens again, and I sort of go, oh, why has this come back?

T: I was thinking it's a bit like the way you deal with feelings too, that you kind of just want them to go away, wait for them to go away. You just don’t want to think about it…but wait for it to pass.

Emily: Yeah, I'm kind of used to being ill, like always having colds and stuff. I always seem to have a cold.

T: So it feels there's often something wrong?

Emily: Yeah, often I normally get cold sores and mouth ulcers and eye infections and things like that. I don't know. It's normally when I'm tired or when I'm stressed because they are signs of the immune system.

T: So it's a sign to you're a bit run down or something?

Emily: Yeah, and I need to relax.

After a long silence, Emily said she had nothing to talk about. The therapist then linked the funeral and the burial, and the fact that they had taken it out of Emily more than she imagined. Emily said she had not really thought much about it, and then talked about something positive. It seemed that, when the therapist tried to address Emily's feelings and how she coped with them, her reaction was either to present and talk about physical discomfort or change the subject to something positive, as if she wanted to stay away from her feelings.

4-3 Withdrawal or withholding from the therapeutic relationship

When the therapist tried to explore the difficulties related to the withdrawal from the therapy or the vulnerable feelings behind it, the patient was often silent or resistant to

the exploration. When Andy talked about stealing food three times a day, his therapist linked it to his childhood experience.

T: This situation with kind of stealing food is something that goes on, something that perhaps was there from an early age.

Andy: My parents used to let me shop lift.

T: You told me that… (Andy was using his phone) You like texting as if there isn't just the two of us in here talking, but there's somebody else out there, isn't there, that you're interacting with?

Andy: They're important, they take priority.

T: This is just to make me know there is somebody much more important than talking to me here.

Andy: I'm still listening.

T: It would be more frightening if it was just the two of us listening, talking and looking at each other. It's easier to have maybe your phone, or to have a leaflet or something else to read.

Then he became quite withdrawn for the rest of the session. He seemed to try to avoid the contact with his therapist as a way to cut himself off from the vulnerable feelings when they were held by his therapist. His pattern seemed to be 'feeling vulnerable,

vulnerable feelings being addressed by the therapist and held by the therapist, and then he withdrew himself from the contact with the therapist.

When Debby's therapist made a transference interpretation about him not taking her feelings seriously, he did not do his job well. It would have better for him be a kind of punch bag.

Debby: I'm still seeing my counsellor… this (psychotherapy) is more medical… it's less of a coffee chat and more like a doctor chat… Because medical is very… clinical. Like, I think they're very…

T: Emotionless.

Debby: Yeah, right.

…

Debby: I'm not sure if what I said was insulting… the room is very clinical and blue and has a sink in it.

T: Why does it have a sink, you mean? [Yeah.] What's the point of that?

Debby: Yeah… It's a sink. It looks like either a bathroom or a medical room. And it's blue and it just feels like… like a mental clinic… And (there is) a really tiny chair. And I don't know, just the room is so mismatched and weird.

T: (it) sounds like you are saying, this is my session. What the hell is a tiny chair

doing here? I'm not a little kid. You know, this is wrong… maybe it sort of feels a bit unfriendly, really, in a way.

Debby: (Talking about the room being unfriendly and sterile)… I don't understand if there was like an operating table or an oven... The lights are really bright.

…

T: I guess I'm talking about them with the expectation that (what she says) they're going to be analysed, rather than listened to.

In this discussion, Debby emphasised twice that 'it's not insulting' and 'it's not personal (talking about the therapist)'. However, her very rich association of the room, psychotherapy, and the therapist, seemed to have quite a lot of feelings that she had in her therapy, and she was withholding them rather than talking about them in the session.

4-4 Passive withdrawal

Different from the typical withdrawal as an attempt to avoid something unwanted or aversive which is a proactive choice to some extent, there is another type of withdrawn state, which is more passive due to the patient being helpless. The patient knew the difficulties, but could not find a way to change things and make them different. There was a sense of 'I have no choice', but it was not real acceptance; instead, it was like

feeling ‘resigned’.

The reason I did not choose to categorise this subtheme into ‘a sense of helplessness’ is that this passive withdrawn state may produce results similar to a typical withdrawal, which can become a vicious cycle. It’s as if the patient wishes for change in his/her mind, but there is no hope of change.

Ched had struggled with social difficulties at school.

Ched: I think a lot of the stuff happened at school, and now I'm just learning to not really care anymore… It's just, I've sort of accepted it.

T: What have you been learning to accept?

Ched: Just the fact that the way things are now must be how they're going to be for quite a while.

T: …in terms of the social situation? [Yeah.] Right, yeah. Based on what?

Ched: I don't know. Nothing really bothers me that much now.

T: ... So the way you're dealing with it is to kind of not let it bother you.

Ched: No, it still bothers me. It's just I'm not letting it annoy me to an extent. I know it's happening, but I don't really...

T: You're trying to be resigned to it. [Yeah.] ... It doesn't sound like you feel like you could act in such a way that it might change.

Ched: I think it’s going to be the way it is now for quite a while.

T: ... But it doesn't sound like you feel it's forever then, ‘quite a while’.

Ched: I don't know. There's part of me that would like to think that I will eventually sort things out. But at the moment I know it’s not going to be any time soon.

It seemed that it was not that he did not want things to be different. It was more like he did wish things to be different, but he really did not know how, so he felt resigned. Ched discussed how he coped with feelings and thoughts about his social difficulties with the therapist.

Ched: …I still have the same thoughts, but I don’t let it dominate me that much. But it’s not like my problems are gone, they’re still there. But I try to purify myself with something else. I mean I haven’t been able to do anything over the last two couple of days. I’ve just been sort of sitting and playing with Xbox… I can’t really go anywhere. And that’s sort of brought me down because I can’t really do anything and I hate it when I’m sitting around all day.

…

T: If you’re going to sit and wait for someone to phone you, I suppose by your own account, you might have to wait a long time.

Ched: Yeah, even so, I don’t have anyone to call.

…

Ched: (at school) two friends I used to talk to and still do today. And then one of my ex-friends as well. If I'm already sitting in the class, if I go in first and I sit down, they all come in and sit on the other side of the class. They won't come and sit near me.

As illustrated by the example, it was not just helplessness that made him struggle, but there were also feelings of resignation and passivity in this kind of withdrawn state.

4-5 Results of the withdrawal

Some patients mentioned the results of their withdrawal, e.g. missing things at school or missing the opportunity to achieve their academic potential due to missing school too much. Chad was quite aware of the academic consequences of not attending school.

Ched: I don't a lot of it because I've missed (school) quite a bit… I don't think I've done reasonably good in any of them (exams).

After Ched's therapist mentioned that he had missed more than half of the sessions offered, she addressed the consequences of missing sessions.

T: …I wonder if it's kind of a bit of a vicious circle that you're not sure how it's going to make a difference, and then you don't come, and then, of course, there is

no difference…It's that actually we haven't been having the therapy… It could become a wasted opportunity. That's the worry. I think that maybe that's a bit parallel to what's happened with school and the A-levels. And then you get upset and angry because you've not made the best of the opportunity… But it sounds like you feel that it just is bad luck on those seven appointment times. I don't know if you're being absolutely honest with me, though, are you?

Ched: Yeah, it's not like I'd chosen not to come. A lot of times I couldn't come.

The therapist then discussed whether Ched felt that she was not flexible with the session times. He emphasised that the sessions were missed for practical reasons.

Ched: It's just because, like, it's been exam season as well, and everything's been going on. It's been a bit hectic. But now that's finished, it should be alright.

T: Ok, so you anticipate that you will be able to come regularly, weekly? [Yeah.] Because the point is, you know, that from my experience, unless you maintain the rhythm of the sessions, it can be, you know, not all that helpful, which is a shame.

Since the exploration of the meaning and feelings related to the missed sessions did not go well with Ched, the therapist seemed to change her strategy to check whether he would attending the following sessions regularly, and he agreed. This is the 11th session. He then attended the 12th, 13th and 15th sessions (his final attended session).

Ched briefly talked about why he attended the exams.

T: It is a huge relief it sounds that the exams are out of the way regardless of the result.

Ched: Yeah. The only reason I sat the exams was because I would have had to pay for them if I didn't.

He seemed to convey that he had attended the exams because there would be an unwanted consequence if he did not. He also talked about the revision lessons he attended.

Ched: I think it was the last three hours (of revision lessons)… Those were the lessons I had on Friday which I missed quite a lot of.

T: Right. I suppose it's a bit of a dilemma or a clang stick or something because if you feel you can get away with doing this very last minute cramming and stuff, might there not be a bit of you that would think, well, what's the point of going to the lessons every day and doing the same as other people?

Ched: I don't know. If I did actually revise and I did go to all my lessons, then I reckon I would have got a decent grade, but since I haven't and I've got some of it right. I reckon if I applied myself to re-sit in January, I would get something decent.

Ched seemed to be in touch with what had been missed and what the consequences were, but not in a desperate tone, as there seemed to be consequences for repair too, i.e. revision lessons.

Emily had a special rule for herself that she would not miss two sessions in a row.

T: You sort of didn't come last week, so perhaps you felt you had to come this week. But kind of missing two in a row feels a bit too much to miss, that you would worry that.

Emily: Yeah, I don't think you should miss two.

T: Right. That's your rule for yourself, is it?

Emily: Once you miss two, you can, I think you just get out of the habit. And that's all, I don't want to go anymore.

It seemed that in Emily's mind, the consequences of missing more than one in a row were missing them all. She later talked about how she missed year 11 a lot, and she talked about her friend, E, who was currently not attending school.

Emily: I wasn't used to not liking school and then I sort of stopped going. Yeah. I miss year 11 a lot… I used to work quite hard, but I actually had lots and lots of fun in lessons, but now because I don't really have, none of my friends really or

like except in classics, none of my friends are really in my classes.

T: You've gone down a year, haven't you?

Emily: Yeah, I mean even like last year none of my good friends were in my classes. So it was just quite weird, because I went to the party where I had my really, really, really good best, closest friends at the time all in my class.

…

T: You haven't made any new friends?

Emily: Like I speak to them and I do know them like and it's quite nice, but it's still quite a reserved kind of thing, because they're all in the same year, so they all hang around together and spend lots of time together whereas I'm not, and all of my friends are in the year of class.

T: So you feel a bit out of it?

Emily: Yeah, I mean I still see all my friends, well except for E (a friend)… she's sort of, for the past couple of days she hasn't been in. I don't know what's up with her. I know, I just like, if I can, if I can help… instead of like having a go at her for not coming in, I just called her up and told her all the news, like stuff that she really needs to know. I sort of went, you know, you need to come into class, you need to come into school because you do need to talk to this teacher about like university things and stuff… I'm worried but I'm trying to just kind of stick out a

> bit and not get too involved with it and that. I obviously want to help E but I don't think there's much I can really do to like force her to come into school. So all I can do is that, when she does actually come back to school, I can make it easier for her.

As Emily had also missed school a lot in the past, she was suffering from the consequences by not being able to be in the same class as her friends and she currently had no friends in her lessons. Apart from this, she seemed to know about the complexity of withdrawal from school quite well, and that there was little that she could do to help E as a friend. She was quite aware of the consequences of missing school, especially at the time of getting into the next stage of education.

Chapter 5: Discussion and Conclusion

5.1 Reflection on the research journey

The findings of this study consist of the repeated themes that were identified in the reunion sessions of the five patients who were categorised as dissatisfied dropouts. As the aim of the analysis was not to present the characteristics shared by all five of these patients, the themes presented in the findings do not apply to them all; hence, the findings do not apply to all dissatisfied dropouts. The analysis is an attempt to present ‘what they could be like’ rather than ‘what they are like’.

Before discussing the findings of the thematic analysis, I would like to reflect on my research journey. For various reasons, there was quite a long gap between when I began to transcribe the selected audio recordings and when I started to analyse the data. Hence, there is a parallel with my research subject in terms of absence and reunion because I had quite a long absence from this doctoral research, and a reunion with it. When I restarted (reuniting) the study, there was a sense of something quite different, but also a sense of something the same. It was different in that, when I initially started the study, it was when I had just completed six years of child psychotherapist training as an overseas student in the UK. As my main training as a child psychotherapist was delivered in English in the UK, when I started to work on this study, both my clinical

work and research work were all in English, and the first thoughts that came into my mind in clinical and research encounters were all in English. However, when I was reunited with the study, I had been settled both in terms of clinical work and my personal life in my home country, a Mandarin speaking country. Hence, when conducting the analysis, although the material was in English, the first thoughts that came to mind were in Mandarin, and the draft of this dissertation was firstly written in Mandarin.

Therefore, when I became reunited with this project, I was in quite a different position in terms of language. However, what remained the same was that, whether I was first listening to a recording and reading the transcript, or whether I was re-listening and re-reading, the material triggered a great many thoughts and feelings in me when I became reunited with the project. I was intrigued by it, to the extent that I was really concerned about some of these patients, even though I was not collecting the data myself, but was a third person looking at it. It was a real privilege to have the opportunity to participate in a clinical encounter with these patients and therapists from a third person perspective, not as a clinician attending a case discussion seminar, but as an observer, so that I could put aside my role as a clinician (to some extent), and immerse myself in the clinical encounters presented to me.

5.2 Perspective of this study

5.2.1 My role as an observer

Although reunion after planned breaks is a well-thought subject in psychoanalytical work, even to the level that psychotherapists will bear it in mind that feelings and thoughts about the break (the planned long gap) may be something that patients bring up in the first few sessions (reunion sessions) right after the break, whether they talk about them directly or bring them up in the transference/countertransference. However, to my knowledge, there is no research that is focused on the first sessions attended after missed session(s), which I call reunion sessions. Therefore, the focus of this study is to explore the phenomenon of a reunion, which is to present what reunion sessions were like without attempting to explore the technical issues or explanatory/inferential interpretations.

As a child psychotherapist, I had a great many associations when I was reading the transcripts. For example, if I was to read these materials in a case conference seminar, I may want to share my thoughts about why Andy stole food three times a day after he lost the income support from the social worker. My association is that of a starving and deprived baby as the breast finally showed up in front of him, but it suddenly disappeared or was perceived as being suddenly withheld, so that the baby angrily

pulled the breast back, sucking it relentlessly, as if it owed him so much that he had become entitled to take back as much or more milk than he wanted. As a child psychotherapist whose major training was in the Kleinian approach, I had a lot of associations in terms of object relationship while reading the material. My research supervisor advised me to write them in another notebook as a way to leave them aside during the analysis, but keep them close in order to return to them in a discussion. I found this advice quite helpful, so that I didn't have to supress my clinical thinking, but allow it to emerge and find another place for it. There is a big difference between being a researcher and a therapist, as Hinshelwood (2007) proposed:

> 'the nature of psychotherapy is the intuitive production of hypotheses - they are for trying out with the patient. We do not work to build up evidence before making a hypothesis as in other forms of science; in fact the reverse, the process of therapy is to try out hypotheses with the patient. Our evidence comes from watching the fate of our hypotheses.'

However, as a researcher, I have no opportunity to try out my hypotheses through interpretation, and watch the patient's response to see if they are close to his/her experience. I have to take a step back, think and analyse the material, and present my hypotheses as themes that are based more on evidence shown in the material rather

than my association. Nevertheless, whether through training or at work, I have a disproportionate experience in doing clinical work and in doing research. Although I have made an effort to distinguish the two roles and to keep my clinical thinking alive while switching to a researcher's role, I find myself still like a therapist to some extent, who knows the difference between a clinician and a researcher, but is trying his best to undertake this research.

5.2.2 Descriptive approach

Although this is a qualitative study, it is different from interviewing either the patients or the therapists about their experience. My position as a researcher in this project is that the research analysis is an attempt for me to take a third person perspective by watching what happened between the patients and therapists, trying to understand both parties' experience, bearing both parties' roles and responsibilities in mind, as a 'bridge perspective', to explore their experience against the clinical encounters of the reunion sessions. This bridge perspective is not an inferential attempt, but a descriptive one.

Since only one session of each of five patients' course of STTP was analysed, it was impossible to differentiate the themes identified in terms of whether they were mainly related to the reunion, or to the patients' characteristics, the therapists' characteristics,

experience of the past sessions, and other unknown external/internal factors. As the nature of the data used in this study was segments of the patients' STPP journey, the findings may not be meaningful if there is too much focus on presenting material objectively; however, if I, as a researcher, interpret the material mainly subjectively, the findings may not be close to what really happened in the clinical encounter. This study is an attempt to find a balance between these two positions, but bearing in mind that the findings were identified by me, rather than just emerging grom the data (Braun and Clarke, 2006).

5.2.3 Reunion as a stepping stone for understanding the dissatisfied group

It would be quite a leap if the construct of reunion itself had not been developed, but it was used as an entry point to explore dissatisfied dropouts' clinical encounter. It is important to clarify that the focus of this study is not to establish the construct of reunion sessions, but the entry point of reunion sessions is used in this study as a stepping stone for a better understanding of dissatisfied dropouts. There are other meaningful entry points for this purpose, e.g. the final session attended by dissatisfied dropouts,[4] the early sessions they attended (O'Keeffe *et al.* (2018) indicate that a therapeutic alliance in the early stage can predict the treatment outcome), or a comparative study of the

[4] To my knowledge, another researcher was interested in this subject, and may have started to work on it.

difference between dissatisfied dropouts, non-starters, etc.

While reading the transcripts, I was very surprised that three patients other than Andy and Ched, who seemed to be very withdrawn and deeply stuck in desperateness, were categorised as dissatisfied dropouts. It was difficult to determine, to some extent, the subsequent trajectory of these patients while I was reading the material, because it is crucial to bear in mind that in the research of O'Keeffe *et al.* (2019), three categories of dropouts was based on interviews with patients after the treatment had ended. There was quite a gap in terms of the time between the sessions I selected to the time the patients were interviewed for O'Keeffe's research; therefore, a lot could have happened during this gap, whether between the relationship of patients and and therapists, or in the patients' lives.

5.3 Reflection on the idea of a reunion session

As the methodology of this study is not the grounded theory, its aim is not to develop the construct of a 'reunion session'. However, I find the topic below worthy of reflection.

There is always a gap in terms of the time between sessions; the gap is longer for non-intensive psychotherapy than for intensive psychotherapy. Hence, after the first

session, all the other sessions have the nature of a reunion because there was an encounter with the therapist in the previous session, then there was a gap when the therapist was temporarily unavailable, and the next session was a reunion with the therapist. As mentioned earlier, planned breaks, such as extended gaps, is a theme that psychotherapists will bear in mind before and after breaks. Once the patient has become accustomed to the regularity of separations and reunions within therapy, their reaction to any subsequent interruptions, whether planned or unplanned, merits the therapist's close attention.

Although understanding the adolescent's psychotherapeutic experience through the lens of attachment styles could be valuable, the aforementioned developmental issues make it difficult to assess adolescents' attachment styles with the existing tools that are designed for children or adults. Therefore, the issue of psychotherapy dropout was not explored from this specific perspective in this study.

As Rosa (2017) mentions, 'By its nature, psychotherapy always deals with issues of separation and endings, but this feature comes especially to the fore in short-term work.' There is a type of separation when the patient will not see his/her therapist again, which is called an ending. There is another kind of separation, which is a reunion that follows a separation. This is in the context that patients are willing to

attend their sessions, i.e. they have not dropped out of their therapy. From the perspective of dropout, it is quite different, and reunion sessions are times that patients are still willing to come back to their therapy. If they are not willing to come back, they have dropped out from therapy.

Based on the link between reunion and willingness to come back to therapy under the circumstances of dropout, is the quality of the separation (gap between sessions) the same for completers and dropouts? Is the quality of reunion the same for them? If not, what are the differences? As the sessions selected for this study were not the final sessions attended, they were other sessions before the final sessions were attended. This makes me wonder if there is a spectrum of ambivalence about attending therapy. Combined with the level of patients' engagement with therapy, are highly engaged completers at one extreme of this spectrum, and poorly engaged dropouts at the other? Is it the case that the patients in the sessions included in this study are struggling somewhere in between these two extremes, so that they are still currently attending, but will be finally moved to the side of the poorly engaged dropouts? These hypotheses are worthy of future research.

5.4 Reflection on the findings of this study

Some themes and subthemes are interrelated; for example, the two main themes

‘sense of helplessness’ and ‘signs of withdrawal’ are related, or may be the cause of one another. One may decide to withdraw from school due to feeling helpless with social difficulties, and it can be the other way round or become a vicious cycle.

Under the theme of ‘sense of helplessness’, ‘lack of hope toward change’ and ‘limited space for thinking and reflection’ are related. The latter is focused more on the issue that, although these patients are struggling with their difficulties, and they attended their sessions for help, it then became an issue of not only limited space for thinking and reflection in their minds, but also limited space between the patients and the therapist. As mentioned earlier, if these three traits are coupled with signs of withdrawal, they engender a vicious circle to some extent. This could be broadly characterised as 'difficulty in being helped', wherein the opportunity for 'getting help', even when present, cannot be effectively utilised. Clinically, I have observed that a number of adolescents presenting with withdrawn-type school refusal manifest this difficulty.

The subtheme ‘passive withdrawal’ is related to the main theme of ‘sense of helplessness’. This subtheme is further emphasis of a subtype of withdrawn state, which is more passive due to the patient’s helplessness, rather than proactively choosing to avoid something, and passive withdrawal has a ‘resigned’ quality which

will be discussed later.

Although this study is not an attempt to develop a construct or concept, but to try to capture the richness of reunion sessions, some themes like aggression and sadness were identified, but were omitted from the thematic map. Aggression is a common issue in adolescence, but the codes identified in my analysis that were related to aggression, which I interpret as characteristics of adolescence. ‘Sad’ is the word for affect that was mentioned most in the selected patients, either by the patients themselves or the therapist. However, in my analysis, sad was not identified as a theme, but was related to another affect, ‘helplessness’, and related to triggers of withdrawal.

5.5 Affect of these patients

5.5.1 Depression as an affect and a mood

Compared to childhood depression, the psychiatric diagnosis of depression can be usefully applied to adolescents. The only note mentioned about adolescents in DSM-V is that the diagnostic criteria of a depressed mood in children and adolescents can include irritability. As Sandler and Joffe (1965) propose:

‘…when we approach the problem of childhood depression from work with adult

> patients by the emphasis on the clinical syndromes which we label depression, rather than on depression as an affect, a mood, which may or may not be a prominent symptom in the patient's illness. The designation of depressive illnesses as affective disorders only nominally meets this point.'

Although diagnosis is helpful in assessing if someone's low mood is just an ordinary mood swing, or if it is pathological and in need of attention or treatment, the quality of their affect and mood, and the possible psychopathology are not emphasised in DSM-V. Given that all the participants of the IMPACT study were adolescents with moderate to severe depression, the quality of the selected patients' affect and mood is one of the main focuses of this study, rather than their symptoms or the alleviation thereof.

5.5.2 Sense of helplessness

A sense of helplessness was identified in three of five patients. It was presented in three subthemes: disturbing situations, lack of hope toward change, and limited space for thinking and reflection. For Andy, the disturbing situations that he encountered were too overwhelming in terms of both quality and quantity. He did not manage to stay in college, had financial difficulties, had an abusive friend (in the near past), and had a parent who allowed him to shoplift in childhood. When I read the transcript of

his session, I felt very strongly for him, and wondered if he was not only helpless, but also hopeless, especially when he lost income support from the social worker. According to Arieti (1970), if the ideas of oneself and loved ones that carry emotional valence are not protected and nurtured, it may result in depression.

Given the multiple difficulties, how can Andy maintain the idea of himself being worthy of care and protection and the idea that there can be good future waiting for him? In Andy's mind, the only access to a good future/new life involved moving to another city where his friend lived. It is understandable that his life was miserable here, so that his hope for the good future/new life became moving to the city where his friend, who was the source of goodness lived. However, I wonder if hope might not be the main quality of this wish; it might have a split quality of 'here and there', and it might be more to do with an attempt to change the environment to get rid of all the underlying misery of his current life. Therefore, the main quality might be helplessness due to a lack of hope toward changing his current life here.

For Ched, who struggled with social difficulties at school, when he talked about his dream of a venue where people can gather to play games together, I wonder if it might have similar qualities as Andy's 'here and there' split, in the form of a split 'reality and dream'. He had quite a strong sense of helplessness too.

5.5.3 External disturbances of these cases

For Andy and Bella, whose physical safety was under threat, the severity of their external disturbances was very concerning. I even wondered whether they were too close to the line to be categorised as the 'troubled dropouts' group described by O'Keeffe *et al.* (2019), who had confessed of 'stopping therapy because of a lack of stability in their life which made it difficult for them to engage in therapy'. As Andy struggled with finances and Bella was afraid for her physical safety, their lives were very likely to lack stability to some extent because these are needs at a very basic level.

When some of these adolescents who encountered serious incidents, had to make big decisions, or were feeling sad, they had a similar way of coping. Andy's relationship with the abusive friend lasted 8 months, but he did not tell his therapist until it was over; Bella's life was under threat, but she was not asking for protection from adults, including her therapist; Ched struggled with social difficulties and had nothing to do in the upcoming break, but he did not engage in a discussion about how to make things different that his therapist tried to think of with him; when Emily felt sad, she did not ask for help, but she just wanted it to go away and waited for it to pass. The common pattern for these people to cope with difficulties and difficult feelings is not

to ask for adults' help. This is not unusual for adolescents, given that their development stage is to experiment with their autonomy. However, this pattern can also be viewed from another perspective, as Rustin (2009) commented,

> 'If we put it in the language of attachment, we might suggest that normal secure attachment is indeed the child's link to someone who is capable of being anxious about the child.'

I am not suggesting that those adolescents were insecure attachment types, although this pattern they presented when they encountered difficulties can be viewed as an inability to use the support offered by adults (therapists) who were anxious/worried about them. When they struggled, they tried to cope on their own, and they still did not try to make use of their therapists' help when this strategy did not work. Hence, if the difficulties they were encountering were very disturbing, they would be likely to miss the opportunity to receive the support or help made available to them by having therapy until they became more and more helpless.

5.6 Characteristics of these patients' relationships

5.6.1 Relationship with parents

Andy, Bell and Debby talked about their parents in a negative way. Andy said that his parents allowed him to shoplift, while Bella said that her father did not care about her and her mother did not support her, and Debby talked about having no support from her mother for a project she was keen to do. Although I understand that many people complain about their parents in therapy, especially adolescents, it was unclear if the fact that they were disappointed with their parents was to do with their relationship with them and their characteristics, or more to do with adolescents' development issues; for example, they may have been denigrating their parents to make them seem less important, so that they had more space for relationships outside the family or could allow non-family relationships to become more important to them (Waddell, 2002). Whatever the reasons are, what matters more is whether they can allow themselves to ask for help from their parents or other adults when they are unable to cope by themselves, or that they become pseudo adults with defensive atomy that makes them more vulnerable in a crisis.

From a parental perspective, it is important to remember that it can be quite a struggle to be the parents of a depressed adolescent. Based on research by Stapley, Midgley and Target (2015), such parents may experience emotional turmoil (e.g. upset and distress, guilt and self-blame, be appalled and frustrated), 'parenting in overdrive' (e.g. providing extra parenting for the depressed child, walking on eggshells), and

especially if parents are having to struggle themselves, they may feel helpless too (e.g. competing demands of themselves or siblings, lack of support). As shown in Stapley's research, parents can feel quite helpless and confused when their child is receiving help from mental health services. As expressed by Bella, 'I don't understand the system (of mental health services)', and this can be difficult for parents too. Some of them might struggle with the parental work offered by mental health services, as described by Horne (2000);

> 'For many parents, the sense of shame with which they come to our services acts as a powerful reinforcer of the sense of a "bad" or "imperfect" parent—a projection onto the team of the parental sense of failure with the child.'

This is a reminder that not only is the disturbed young person feeling vulnerable, but the parents of a child with mental health difficulties can feel vulnerable too, making it harder for them to tackle their child's complaint. Cases like Debby can be quite complex and difficult. Her stepfather wanted her to stop having therapy, putting her in a very difficult position in terms of which side she should agree with and whether the other side might be angry with her. Parental disagreement with therapy is a really difficult issue for adolescents to cope with, especially for those who would like to attend, but feel that their parents will not allow them to do so.

5.6.2 Helpful figures

Other family members, such as siblings and other relatives, were not mentioned in a positive way during the five reunion sessions, nor were any helpful adult figures mentioned. The absence of helpful figures was a common issue for all five patients. Although only one session had to be chosen for each patient in the data selection so that the material was not representative, I could not help but wonder if the lack of a mentor type of figure may have been an issue for at least some of these adolescents, as Bemporad, Ratey and Hallowell (1986) described,

> 'who is too old to be seen as a peer yet too young to be seen as a parent…In former days, uncles or older cousins who were removed from the parent-child or sibling rivalries, may have served in such a role, easing the passage to adult life.'

Moreover, if adolescents do not have this kind of mentor figure in the form of their teachers, relatives or therapists, who can provide containment, their friends are the only people they can turn to for help when they are in trouble or a crisis occurs, or themselves. This may make acting out or withdrawal an easier option for them.

5.6.3 Relationship with peers

Friendship was discussed by many of these patients. For instance, Andy talked about

an abusive friend with whom the friendship had just ended, and a good friend who lived in another city; Bella was always with her best friend, B, and they seemed to get into disturbing trouble together; Ched felt excluded and isolated at school and socially isolated during breaks; Debby became quite withdrawn after feeling let down by her friends; and Emily talked about spending time with her friends outside school, because her best friends were not in her current classes. She also mentioned a school-refusing friend with whom she tried to stay in touch. According to Waddell (2002), it is crucial for adolescents to have friends or peers to interact with in order to develop their personality, so that they project parts of their personality onto friends or peers, and then interact with them to determine if they would like to take the projected part back to themselves, or abandon that part of their personality. Therefore, having no friends or peers can be a serious problem for adolescents.

These patients mentioned some types of friendship they had experienced, for instance, with friends they had enjoyed being with and wanted to spend more time with (Emily), friends they would like to interact with, but felt rejected or let down by them (Ched and Debby), an abusive friend who really made one suffer for a long time (Andy), twins like friends in that they were always with each other and knew each other well (Bella), and one friend who was in difficulties and the other tried to help (Emily).

Bella's relationship with her best friend, B, seemed to have the twinning qualities that Waddell (2018) commented on in terms of Narcissus,

> 'Narcissus needed to bolster his self-esteem by seeking a relationship with someone who looked like himself. Could this not be with a mirror image that might restore a fragile self-conception, a kind of intensely experienced twinning relationship, serving as a defence against feelings of isolation, and possibly of smallness and humiliation?'

Was B the friend that served Bella as a defence against her feelings of isolation, fear of aggression and of being attacked, and of being a trouble-maker? Did her friendship serve as a function to hold different parts (e.g. scared and brave) of their personalities together by forming this twin pair, so that they could experience their internal chaos, threat, and aggression in a projected/externalised way? Was Emily trying to explore the undigested school non-attendance/refusal experience of the past by staying in touch with a friend who was not currently attending school? Waddell's view is truly inspiring that some relationships that are important or unwanted in adolescence may serve both a function of defence and one of self-exploration.

5.6.4 Relationship with therapist

Ambivalence toward therapy was the issue most discussed in these reunion sessions, being present in four of the five patients' sessions. Moreover, four of the five patients' sessions also addressed cancellation/rescheduling policies, and two patients seemed to be shocked when the therapists located their position in the timeframe of the STPP course. As mentioned in the 'The meaning of reunion' section, I wondered if it was possible that these patients remained ambivalent toward therapy or the therapeutic relationship during the reunion sessions, and if may have turned to take the side of dissatisfied non-engaged dropouts.

Another question that may be equally as meaningful as the question, 'What was these patients' relationship with their therapist like?' is 'Who is the therapist to them?' As many of these patients talked about their disappointment with their parents, and no helpful adult figures were ever mentioned, could the therapist be a helpful figure in their minds? Or is the therapist just less disappointing or equally disappointing than their parents? Although I have no answer to these questions, based on the clue that disturbing incidents happened or they had difficult times during the missed weeks, I wonder if these patients tended not to attend their sessions when things became difficult. It may have been quite a personal association, but I even had the sense that some patients attended the sessions with a kind of wait-and-see attitude. It was likely that they came to 'watch' what the therapist could do for them, rather than really

wanting to get something from the therapist.

5.7 Issue of withdrawal

The theme and subthemes of withdrawal of this study are quite broad, but in fact, they generally indicate that one removes oneself from contact with an environment, feeling, or relationship. To be able to remove oneself from contact with something, it is assumed that one had contact with something first. This is why I coded them as withdrawal, not poor therapeutic alliance, indifference or dismissiveness. However, if the categories of ruptures of therapeutic alliance summaries of Bengardi, Eubanks and Cirasola (2025) are applied to those cases, quite a few withdrawal ruptures can be identified in Andy, Ched, and Emily's sessions.

I included the type of school non-attendance of the presented patients (Ched and Emily) in the main theme of withdrawal. However, according to Heyne *et al.* (2019), their situation should be called 'school refusal' wherein 'a young person is reluctant or refuses to attend school in conjunction with emotional distress, which is temporal and indicative of aversion to attendance, or emotional distress, which is chronic and is hindering attendance. According to Klan *et al.* (2024), the term should be 'Emotionally Based School Avoidance'. I find those terms and definition accurate in terms of the general phenomenon, but I use the term 'withdrawal' in this study,

because the theory of ‘psychic retreat’ (Steiner, 1993) is on my mind when he described patients’ withdrawal as a type of psychic retreat and the resultant failure to allow contact with their analyst. As he suggested,

> It is important not only to describe the mental mechanisms that operate at any particular moment, but also to discuss their function: that is, not only what is happening, but why it is happening—in this instance to try to understand what the patient fears would be the result if he emerged from the retreat.

I find that the close link between withdrawal, failure to allow contact and fear is useful to include the subthemes.

Andy, Ched, and Emily presented the issue of withdrawal from school, although the cause may be different. It is not surprising that people who had the experience of withdrawal from school also missed therapy sessions because retreat was a strategy that was familiar to them, and I believe that it was useful to some extent in that it alleviated their anxiety by reducing the level of stress due to avoidance of contact. However, it was not without cost, as illustrated by the unwanted consequences that followed.

Ched and Emily presented the results/consequences of withdrawal in their sessions.

When Ched mentioned not getting a decent grade due to missing school a lot, and Emily mentioned that her friend, E (currently not attending school) might find it difficult to apply for university if important information was missing, they were not talking about them in a desperate tone. For Ched, it may be that he was not only in touch with the unwanted consequences of withdrawal, but he was also in touch with the wanted consequences of repair, as he had attended the last revision lessons. As mentioned earlier, Emily may try to understand and help her withdrawn self or past withdrawn self, as she was currently in touch with her non-withdrawn self or reparative self. If they were in the depressive position described by Klein (1935), they were aware of what was lost or damaged and had an urge to repair. However, bear in mind that Ched struggled with a strong sense of helplessness and had limited space for thinking and reflection, and Emily struggled with being in touch with her vulnerable feelings, although she may be able to be in touch with vulnerable feelings when they were projected onto her friend, B. Therefore, even though they presented some signs of repairment, their struggle was still complex and difficult.

In their study regarding the application of CBT for school-refusing adolescents in Japan, Naoki and David (2019) observe that these youths' 'avoidance characteristics' are not only manifest in relation to school, but also in their refusal to attend the treatment institution. They identify this as the principal reason for treatment failure.

Whilst CBT is typically effective for school refusal, its efficacy is inevitably restricted if the adolescent refuses to engage in therapeutic sessions. This phenomenon may be interpreted as 'treatment dropout' in a broad sense, or may imply that treatment never started.

The two subthemes, ‘avoiding vulnerable feelings’ and ‘withdrawal in the therapeutic relationship’ were separated because I identified the former as an intra-psychic phenomenon and the latter as an inter-psychic relationship issue. For example, when patients want to avoid vulnerable feelings, and the therapist addresses them, the patients withdraw from the therapeutic relationship in order to avoid those feelings. The development of adolescents makes it hard to work with them in psychotherapy (Waddell, 2018), and their withdrawal from the therapeutic relationship makes it even harder; their difficulties may be doubled, as they find it more difficult to get help for their issues. Acting out is common when adolescents encounter difficulties. If getting help is not an option and acting out or cutting off become the only option, their situation is very concerning indeed.

Passive withdrawal is the only subtheme in this study that is identified based on one patient, Ched. The reason I chose to identify it as a subtheme, rather than omit it, is because I think including it as a subtheme can make the main theme of withdrawal

richer. What I have learnt from Ched's material is that it is not the same as the typical withdrawal, which is an attempt to avoid something unwanted or aversive and is a proactive choice to some extent; this is a passive type of withdrawn state in which feelings of resignation and passivity are emphasised. When patients are in this state, they may not only feel helpless, but also very lost and confused. It may be that they need someone to draw them a map showing them what path to take to reach the place they want to go to from the current place of nowhere.

This may be close to the state of resignation described by Sandler and Joffe (1965) as a core affective state of depression in childhood. This affect is characterised by qualities of 'giving up the struggle', 'abandoning attempts', and being 'forced into a state of helplessness'. This state is closely associated with hopelessness. It signifies that the child has ceased attempting to restore the lost ideal state, or has abandoned the struggle for gratification.

However, what I have learned from Bella and Ched is that, apart from feeling helpless and unable to do something for themselves, it may be their choice, as avoidance, to keep the current difficult situation unchanged. It seemed that there may have been issues around their tendency to say no to possibilities of change, or to some extent, that part of the reason the difficult situation had lasted seemed to involve the patient's

choice, as there may have been some unwanted elements of the possible changes they wished to avoid. For Bella, gaining the protection of adults may have meant losing her autonomy, and for Ched, having social interactions may have increased the risk of becoming too self-aware.

5.8 Implications for child and adolescent psychotherapists

When I was reading the material, there were moments when I wondered what the patients' experiences were like when their therapists made transference interpretations. I also wondered that after an extended gap (missed weeks), whether transference interpretations assume that patients' absence has something to do with the therapeutic relationship, as if the therapist is present during the missed weeks, but is this really the case? Is it possible that the three categories of dropout, 'got-what-they-needed', 'troubled', 'dissatisfied' can apply to missed sessions too? I.e., are these constructs meaningful, 'got-what-they-needed no-show', 'troubled no-show', 'dissatisfied no-show'?

As mentioned earlier, this study is not an attempt to explore technical issues; hence, I did not investigate the material from a technical perspective. However, given that some patients misunderstood the rescheduling policy, this may be something useful to clarify at the beginning of the therapy when the setting is discussed. There was a

general technical question on my mind as a psychoanalytic psychotherapist, which concerned patients who missed a lot of sessions. I wonder if there are other ways to work with the issue of absence, apart from approaching it by unconscious impulsive desire, transference/countertransference or conflict, and linking the current issues to past experience. For example, could this be regarded as a case management issue? For instance, checking patients' willingness to attend and, if yes, discussing the kind of support they need and being willing to help them to attend their sessions. I do not mean that these approaches are conflicting; I just wonder whether a kind of case management approach that is suitably based on sufficient understanding of the patient's internal and external difficulties might be helpful.

The reunion session was a stepping stone for understanding the dissatisfied dropouts in this study and, although I find this to be a helpful entry point, a reunion session is still an undeveloped construct. The differences between reunion and ordinary sessions, and whether there are different reunion sessions for completers, and got-what-they-needed, troubled, dissatisfied dropouts are both issues worthy of further exploration.

As one of the strengths of the IMPACT studies (including IMPACT-ME) is that the same dataset is used quantitatively and qualitatively, it would be helpful to combine

those findings. For example, as the findings suggested that 25% of the dissatisfied dropouts still met the diagnosis of depression by 86 weeks (Goodyer *et al.*, 2017), what can we learn from the reunion or final session attended by subgroups of dissatisfied-improvers (depression alleviated) and dissatisfied-non-improvers (still meeting the diagnosis of depression)?

5.9 Limitations of this research

When I applied for access to the dataset of the IMPACT study for my research, the data selection was based on the three types of construct in the study of O'Keeffe *et al.* (2019): 'dissatisfied', 'got-what-they-needed', and 'troubled'. There are two more studies in which other categories of IMPACT study participants have been identified because they were published after the completion of my data selection process. Two types of improvement for depression were identified in Davies' study (2020) as continued improvers and halted improvers (Davies *et al.*, 2020). In another study, Fiorini *et al.* (2023) identified three types of improvement for general pathology factors: rapid decrease, slower but steady improvement, and no improvement. It is a pity that I have not been able to link the patients I included in my study to their research because it would have been interesting to know the types of progress they have made in terms of depression and general pathology. According to O'Keeffe

(2019), ‘dissatisfied dropouts were critical of the therapy they received and described various things about the therapy they did not like or find helpful, such as the therapists’ approach to therapy, and issues regarding their relationship with their therapist. They reported stopping therapy because they did not feel they were benefitting from it.’ Therefore, this study is focused more on what happened in their therapy and the therapeutic relationship, not the progress.

Although the small sample size offered me the opportunity to take a detailed look at the material and keep each patient’s characteristics in mind during the analysis, the weakness of a small sample size is the limited extent to which the results of the study can be generalised to the target group (dissatisfied dropouts). The patients were all selected from the same research branch; therefore, there must be some local cultural or sociological characteristics that presented more in this sample pool than in others.

Moreover, only one reunion session was selected for each patient, which meant that I had very limited knowledge of the patient’s history and present life as told in previous and later sessions, and the history and later developments of the therapeutic relationship. An analysis based on very limited data also limits the extent to which the results can be generalised, not only to other participants, but also to the patients’ whole therapeutic journey.

Apart from the small sample size, there was no comparative group for this study, such as completers or got-what-they-needed dropouts, or a comparative group for the non-reunion sessions; hence, it is uncertain if the findings also apply to other groups or other types of sessions.

As mentioned earlier, I described my role as that of a third person observer, a bridge perspective that keeps both parties' roles and responsibilities in mind, but as a single researcher of the study, I had no opportunity to discuss the material and the analytical process to try to balance my subjectivity. Hence, the findings must, to some extent, have been influenced by my experience and interest. The other issue with this third person position is that I was unable to liaise with the patients and therapist; therefore, it is possible that they may not agree with my findings and hypotheses.

I did not collect the data for the study myself. As it consists of audio recordings of sessions, there must be a great deal of non-spoken material missing from my dataset, such as facial expressions and non-verbal language, so that what is perceived as the total situation by the patients/therapists and myself is likely to be different.

Because the aim of this study is to understand dissatisfied dropouts through the entry point and I am a single researcher, the 'fate' of the patients' therapy is blind to me. It is always on my mind that the patients I am analysing dropped out from their therapy

because they were dissatisfied. My observations and analysis may be biased or even shaped by the knowledge of that fate compared to a blind colleague researcher.

For me as an overseas student with my own cultural and sociological characteristics, English is not my first language, and there was a long gap between when I returned to my home country and started analysing the data, so my English fluency is certain to have decreased. This factor may have contributed to some differences in my perspective with that of readers or researchers from other backgrounds.

However, bearing these limitations in mind and, as this study is a doctorate project, the aim has been adjusted in order to not generalise the findings or compare other groups or types of sessions, but to position the study as an attempt to understand dissatisfied dropouts from therapy and pave the way for future research in this field.

5.10 Conclusion

The aim of this study was to explore and understand dissatisfied dropouts through the entry point of reunion sessions (first sessions attended after missed session). This is the first study that used the entry point of reunion sessions for the exploration of an in-therapy process, but it is important to bear in mind that this idea has not been developed as a construct based on research such as the grounded theory. I find the

reunion session as a helpful entry point for the aim of this study, because both absence and presence were discussed in the majority of the reunion sessions presented.

Four main themes were identified: Absence and reunion, Sense of helplessness, Turning to peers, and Signs of withdrawal. The theme of a sense of helplessness was presented in three of the five patients; no matter what the trigger is, it is possible that a sense of helplessness can be a patient's state of mind or affect, but it can also become a transference issue if the patient's space for thinking and reflection is limited. Signs of withdrawal was the most common theme presented by four of the five patients selected. Signs of withdrawal can be presented in avoidance of contact with an environment, vulnerable feelings, and therapeutic relationship. The pattern of passive withdrawal was only presented in one patient, and the characteristics are feelings of resignation and passivity.

The perspectives of affect and relationships in the reunion sessions of dissatisfied dropouts were emphasised in this study. The findings are just a stepping stone for future research in this field. Further studies of adolescents who drop out from therapy and of dissatisfied dropouts are needed to better understand this group of adolescents by reducing the obstacles for attending therapy.

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Appendix

TREC form