Institute for Clinical Social Work

Clinicians' Experience of Their Impact on Missed Appointments

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Abstract

The missed-appointment rate in outpatient psychiatric clinics has been a problem for decades. Many studies and research projects have attempted to understand and modify the phenomenon. Summaries of this research are included in this dissertation, along with discussions of the significance of the therapeutic relationship from the psychoanalytic and social-work literature.

This dissertation reports on a qualitative study undertaken to discover clinician experience with missed appointments in outpatient psychiatric clinics. Little prior research has addressed this specific topic. The researcher believes that the clinician is a key player in the therapeutic dyad, and therefore can have a great deal of influence on clients keeping appointments. Twelve clinicians from two different community mental-health clinics in Maryland were interviewed to ascertain their views.

All 12 clinicians identified qualities, characteristics, attitudes, and behaviors of theirs that impact clients' engaging and continuing in treatment. How clinicians respond to no-show clients may correspond with the degree of connection-versus-distance in the client-therapist relationship. The clinic environment, including agency policies and management oversight, constitutes an additional factor that affects therapists and their work with clients.

For Margaret, Anthony, and Kenneth Sadauski

You are never too old to set another goal or dream another dream.

~C.S. Lewis

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Chapter I

Introduction

Description of the Study

This study explored how clinicians experience their impact on missed appointments in outpatient psychiatric clinics. This is a qualitative research study. Twelve clinicians at two clinics in Maryland were interviewed using constructivist grounded theory (Charmaz, 2006). Open-ended questions were asked initially, followed by specific follow-up questions. Interviews were audio-recorded and transcribed by the researcher. Data were analyzed using Atlas.ti software, and organized into similar groupings (codes). Codes were reviewed repeatedly and compared with each other, at which point themes became evident. Larger, overarching conceptual categories were developed to illustrate the meanings found in the information provided by the research participants.

Formulation of the Problem

Client retention in outpatient mental-health clinics has been a common problem (Barrett, Chua, Crits-Christoph, & Gibbons, 2008—among many other groups of researchers). Low attendance rates interfere with the flow of treatment and shorten treatment for clients who drop out prematurely, thereby decreasing the potential for client improvement. Low

attendance rates affect the fiscal health of institutions, and therefore the potential for serving a greater number of clients.

Psychotherapy can be difficult and resistance is ubiquitous. Resistance can contribute to missed appointments. Factors that contribute to client retention have been studied to some extent. Many of the studies have focused on (a) client diagnoses, (b) socioeconomic status, and (c) client characteristics. Some practitioners believe tangible incentives such as money should be offered, while others portray such incentives as undermining the therapeutic relationship (Burns, R. & Shaw, J., 2007). Many community psychiatry clinics have tried to improve compliance through reminder phone calls and other administrative practices (Sims, H., et al., 2012). Clinicians' opinions about their impact on kept appointments has not been extensively studied.

General Statement of Purpose

The purpose of this study is to investigate how clinicians view their influence on the missed-appointment rate in community psychiatric clinics. How do clinicians assess their impact on regular therapy attendance? Do they feel they can influence attendance? If so, what factors do they believe are important? What personal qualities, characteristics, attitudes, and behaviors, regardless of theoretical orientation, do they consider valuable?

The no-show rate in community mental-health clinic is high and not well understood. When clients miss appointments, clinician time is not well-spent and opportunities to serve other clients are limited. Failed appointments may indicate that the client is not being served as well as possible because people speak with their feet about how well their needs are addressed. In addition, fiscal efficiency is important. Payment for services decreases with

missed appointments. If clinicians believe they can influence clients' attendance, this information is important to know and understand.

Significance of Study for Clinical Social Work

This study can add an important piece of knowledge to the literature. Since many clinicians currently serving in community mental-health clinics or outpatient mental-health clinics are social workers, this research can inform the field of social work. This study presents invaluable information about clinicians' experiences and thoughts on the issue of missed appointments, and their ideas about how their personal traits affect client attendance. The clinician is a key component of the treatment relationship. Focus on this aspect of therapy has been neglected, as we see the growing popularity of "evidence-based" practices that emphasize technical skills, not the importance of the "relationship." As Barrett and others (2008) propose:

> Regardless of the direction for research, focusing on the reduction of attrition can enhance the effectiveness of existing treatments and may prove a more fruitful direction in improving therapy outcome than continuing the focus on randomized clinical trial of new treatments (p. 261).

Foregrounding

I entered the field of social work many years ago, driven by a desire to help people affected by mental illness. I have worked as a psychotherapist for over thirty years and my interest in this project developed out of my enthusiasm and interest in my work. The setting in which I currently work is an outpatient community psychiatric clinic in the inner city of Baltimore, Maryland. Clinics such as mine have been dealing with the problem of high missed appointments rates for many years.

I believe in the power of the clinical relationship in affecting clients' lives. I believe that the clinician is a critical entity in retaining clients in treatment. At the same time, I realize there are other elements that can affect kept appointments. Many of these other factors are beyond the control of client and clinician. Prior to initiating my research, I did not have solid evidence about the extremely influential role that the clinician has on missed appointment issue. However, my concern with a tendency to label or dismiss clients who miss appointments has led me to search for a better understanding of what happens in the therapeutic relationship that might help explain why clients miss appointments or terminate treatment prematurely. I have used the clinicians' experience of missed appointments as a window into gaining some insight into the problem.

My approach has been hermeneutic or interpretive, as opposed to empirical. Results represent the reality that has been co-created through the interaction between myself and the research participants.

Chapter II

Literature Review

Introduction

This paper will present material from early psychoanalytic theory as well as newer clinical theories. While community clinicians do not practice psychoanalysis, concepts from psychoanalytic theoreticians continue to influence psychotherapy practices. Material from the social-work literature will also be presented.

Research has already addressed adherence to treatment and the importance of reducing the percentage of missed appointments. Some of this existing research is presented in this dissertation. External and practical factors (e.g., transportation, lack of funds, babysitting arrangements) affect client attendance at community clinics. However, these factors do not fully account for clinician influence on client compliance regarding appointments.

This paper cites many research findings from studies on (a) dropouts from treatment, (b) early treatment termination, and (c) missed appointments, meaning an appointment in which the patient fails to show or does not cancel at least 24 hours before the scheduled appointment. The core phenomenon is a client failing to attend a scheduled, planned appointment, whether this proves to be the last appointment, or it interrupts ongoing treatment. Through the absence, the client communicates something to therapist. This might be dissatisfaction with the treatment, a desire to leave therapy in general, or something else

that does not come up during therapeutic conversation. What do missed appointments convey about the working relationship between client and therapist?

This review also includes a discussion of the therapeutic alliance or working alliance. Clinicians generally understand that therapy depends on the mutual engagement of the client and therapist. Factors relating to both parties contribute to this alliance. This study explores those aspects of the therapeutic alliance that emanate from the clinician and that have not been significantly studied. This dissertation will highlight the notion of the "real relationship" in the therapeutic encounter. The literature review includes a discussion of countertransference, with an emphasis on therapist response.

This dissertation presents existing research on factors contributing to the attendance and missed appointment rates at various facilities. Other studies cited herein discuss how the person of the clinician plays a critical role in the development of the therapeutic alliance, and subsequently, attendance rates. This involves the phenomenon of the working alliance, which can withstand the difficult and sometimes painful therapy experience. The alliance can sustain the client when the therapeutic endeavor becomes challenging. The researcher assumes that such an alliance creates a greater probability of a positive outcome in treatment. Since the first step in establishing a good working relationship lies primarily with the clinician, it is important to know what clinicians think about their role in building a strong therapeutic alliance.

The Missed / Broken Appointment

We need to understand what a missed appointment may mean, or represent from a psychological standpoint, beyond the client's stated reason. In *The Broken Appointment: A*

Non-Verbal Message (1977), Sidney Love highlighted the importance of understanding the meaning behind this behavior, stating, “Broken appointments may indicate a cessation of verbal intercourse, yet the patient is simultaneously conveying a nonverbal message” (p. 1). Elsewhere in the same work, Love wrote:

> Therapists may often feel that they failed to help when their patients break appointments. However, practice-oriented modern psychoanalytic experience indicates that this behavior in treatment can often provide an additional opportunity for the analyst to assess and resolve a particular resistance which the patient expresses by breaking an appointment at a particular time in his treatment. (p. 7)

This study does not focus on the particular resistances of clients. However, when a client gives a reason for a missing an appointment and the clinician accepts that reason at face value (or attributes the missed appointment entirely to external factors), it is possible that the clinician increases the likelihood of the patient continuing to miss appointments. What the client does is always done in relation to the therapist. The missed appointment is a communication that deserves a place in the therapeutic dialogue. Because the therapeutic relationship is a dynamic situation, the missed appointment is not simply communication from the client to the therapist. It also has a direct impact on the therapist, which in turn impacts the workings of the unique therapist-client relationship. What is the attitude of the clinician toward the broken appointment? Does anger at the patient cause the clinician to ignore an exploration of the meaning of the missed appointment? Does the therapist feel insulted, deprioritized, or abandoned? Does the therapist dismiss the importance of the client’s presence, without realizing the impact of a clinician’s attitude on how a client perceives attendance? How can the clinician address the client’s behavior or reflect

insightfully on countertransference? The number of missed appointments may reflect a clinician issue and / or a failure to address the meaning of the missed appointment with the client. Yet research on missed appointments often neglects all these questions and considerations.

Perhaps we can learn a lesson from the earliest example of this therapeutic dynamic. A century ago, the founder of psychoanalysis may have influenced a patient, Dora, to suddenly drop out after 11 weeks in treatment. This is not a "broken appointment" but a "broken treatment." Freud wanted his work with Dora to gather further evidence of the Oedipus complex and confirmation of the role of repressed sexuality in the development of hysteria (Ornstein, 1993). Freud offered interpretations to Dora to explain her symptomatology (1993). We can gain insight into Freud's contribution to the failure of Dora's treatment by considering his preoccupation with his own goals, to the exclusion of the patient relationship.

> Freud's preconceptions made it impossible for him to listen to Dora's own subjective view, entertain its possible merits, and then search for a deeper understanding of her experiences. Freud did not understand Dora because he omitted the systematic use of "understanding" (the *first* step in the interpretive process) and proceeded to a systematic use of "explaining" her symptoms and behavior (the *second* step in the interpretive process). Whenever one step is omitted, the likelihood of arriving at faulty explanations, and their unacceptability to the patient, increase (Ornstein, p. 70).

Angered by Freud's insistence on his own interpretations, and not feeling understood by him, Dora fled treatment. However, we might consider her protest as a sign of healthy anger toward men of her time and a society that imposed its culture on her, independent of her own views and opinions (Weissberg, 2005; Ornstein, 1993):

> From Dora's perspective, her revenge [leaving treatment] might have been that she reached the limit of her tolerance for being misunderstood, discarded, used, or exploited again, for Freud's purposes. If so, her abrupt departure might actually have revealed some hidden strength in self-assertiveness that she could not exercise in her life outside of the analysis except through the covert manner of her symptoms and behavior. She refused to accept Freud's reality as her own (Ornstein, 1993, p. 76).

In Ornstein's view, Freud's failure to understand Dora led to her dropping out of analysis with him.

Although Freud (1909) was unable to retain Dora as a patient, he was very successful in retaining and treating the Rat Man until the successful termination of analysis. We find that Freud's personality and personal relationship figured into the treatment (Lipton, 1977). Kiersky and Fosshage (1993) refer to two levels of discourse in the Rat Man case: the interpretation of the conflict between patient and oedipal father, and the second level which Lipton calls the "real relationship." Lipton explained that this second level

> …consisted of transference and countertransference enactments during which Freud offered himself as the idealizable, mirroring father whose genuine interest, affection, and reliable understanding enabled the young man to identify himself with a capable and loving male and to self-delineate without fear of loss" (Kiersky & Fosshage, 1993, p. 110, citing Kohut, 1977).

Kiersky and Fossage state, "It is likely that the most powerful therapeutic effects came precisely from the second level of analytic discourse and made possible whatever benefits were derived from Freud's didactic interpretive work" (1993, p. 111). Elsewhere in the same work, the authors pinpoint the benefit of the real relationship, saying, "His [The Rat Man's]

relationship with Freud evidently is secure enough for him to begin to examine his negative feelings toward his father as well as his love for him" (p. 123).

What qualities, attitudes, and behaviors of Freud contributed to the Rat Man's adherence to treatment? Kiersky and Fosshage list the following (p. 131):

1. Freud's genuine interest in the life of Ernst (the "Rat Man") . . .
2. Freud's concern, affection, and generosity . . .
3. The unquestioned force of Freud's personality . . .
4. Freud's confidence in his work . . .

From this point of view, it appears that some personal qualities, attitudes, and behaviors of the clinician (Freud) may have impacted the patient's ongoing participation in treatment.

To understand missed appointments as acting-out behavior that communicates a message via action, we must study many variables in the treatment setting. This study focuses on how clinicians think they impact the treatment alliance with their following attributes:

1. Attitudes . . .
2. Qualities . . .
3. Characteristics . . .
4. Behaviors . . .

The alliance is a foundation for therapeutic work. This study attempts to ascertain which attributes and behaviors of the clinician (as reported and perceived by the clinician) affect the client's engagement in treatment. This critical examination of the therapeutic encounter is often ignored. It is easier to blame the patient for failure to obey rules. To be sure, the client factors prominently in the strength of the therapeutic alliance. However, this study sought to

discover clinician beliefs about variables that help develop and sustain the therapeutic relationship and keep the client coming to appointments.

In *On Learning from the Patient* (1985), Patrick Casement stresses the interactional nature of treatment:

> Whenever I say something in therapy, or continue to say something, I am having an effect upon the patient. I therefore need to listen for the patient's responses to my input, some of which initially may be beyond my immediate consciousness. Listening to myself in the place of the patient can help to bring the dynamics of this interaction more into the field of my awareness (p. 59).

The treatment dyad sometimes includes a dynamic of reciprocal acting-out or enactment, which becomes communication-in-action and prevents an understanding of the treatment process. When this happens, one loses the opportunity to develop the capacity to articulate, which precludes insight. How can the clinician address this anti-therapeutic interchange so to move the work towards a productive outcome? How often are missed appointments dealt with in this way? To have an effective therapeutic process, the clinician must be able to set and hold the frame of therapy.

Aspects of the Clinician / Client Dyad

The following terms deserve definition:

1. Transference . . .
2. Therapeutic alliance . . .

3. Working alliance . . .
4. Real relationship . . .

In addition, this study will address the concept of "countertransference," with emphasis placed on clinician self-awareness and handling of feelings elicited during treatment. "Transference" refers to the ". . . displacement of patterns of feelings, thoughts, and behavior, originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship" (Moore & Fine, 1990, p. 196). Moore and Fine define "therapeutic alliance" and "working alliance" as "cooperation and collaboration in the therapeutic process" (1990, p. 195). In a more detailed description, Bordin (1979) wrote that there are three aspects to this alliance: (a) the amount of agreement between patient and therapist on the goals of treatment, (b) amount of agreement of the specific tasks involved in the treatment, and (c) quality of the bond between the two. The "real relationship" refers to the qualities and behaviors pertaining to the therapeutic pair as real individuals (Moore & Fine, 1990, p. 195). In "On Beginning the Treatment" (1913), Freud discussed specific recommendations for the analyst at the onset of analysis, including educating the patient about the process. In addition, in 1913 Freud wrote:

> It remains the first aim of the treatment to attach him [the patient] to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment and link the doctor up with one of the *imagos* of the people to whom he was accustomed to be treated with affection. It is certainly possible to forfeit this success if from the start one takes up any standpoint other than one of sympathetic understanding, such as a moralizing

> one, or if one behaves like a representative or advocate of some contending party—of the other member of married couple, for instance. (p. 10)

Aside from describing how the analyst helps facilitate the birth of transference, this instruction from Freud also illustrates the importance of the attitude of the analyst in eliciting the patient's cooperation with treatment. The alliance is fostered by the bond of cooperation between patient and clinician.

The concept of "therapeutic alliance" was first described by Elizabeth Zetzel (1956) as part of transference. She said that, "Effective analysis depends on a sound therapeutic alliance," (p. 2), but she also cautioned that the alliance is not to be confused with neurotic transferences.

Transference is the repetition of feelings, attitudes, and behavior toward someone in the present moment that were originally experienced toward a significant person in one's childhood (Adler, 1980, citing Greenson, 1965). Adler believed that the therapeutic alliance in its mature, stable form is often only present toward the end of an analysis when primitive selfobject and other transferences have been worked through and the patient can separate the personal relationship with the analyst from the transference. However, Adler reconsidered this view and specified that the alliance does evolve via the working through of selfobject transferences and other transferences and is not necessarily the end result of the work (1980).

The point here is that the alliance is an important part of the treatment. In "The Working Alliance and the Transference Neurosis" (Greenson, 1965), the author described the necessity of the working alliance for an effective analysis to occur. Greenson pointed out that the working alliance and the transference neurosis live hand-in-hand throughout the treatment. He also described three dynamics in the development of the working alliance: (a)

the patient's role, (b) the analytic situation, and (c) the part the analyst plays. Because the therapist's qualities, characteristics, attitudes, and behavior are the focus of this research, it is helpful to consider Greenson's (1965) discussion of the analyst's role in the development of the working alliance.

> The patient will not only be influenced by the content of our work but by how we work, the attitude, the manner, the mood, and the atmosphere in which we work . . . Essentially the humanness of the analyst is expressed in his compassion, concern, and the therapeutic intent toward his patient. . . . For a working alliance it is imperative that the analyst show consistent concern for the rights of the patient throughout the analysis (pp. 13-14).

Adler (1980, citing Sterba, 1934) described the therapeutic alliance as ". . . an alliance between the analyzing ego of the analyst and the patient's reasonable ego" (p. 2). This collaboration aims at working together to solve a problem or reach a shared understanding. Here it seems that the alliance precedes and is a prerequisite for the analytic work. Zetzel wrote that some analysts consider identification with the analyst as a basis for therapeutic alliance. Some people with ego-development deficits cannot develop a therapeutic alliance (Zetzel, 1956) because they cannot clearly differentiate themselves from the object (analyst). According to self-psychology theory, these patients develop selfobject transferences necessary to sustain their own tenuous self-structures because they are unable to perceive the therapist as an independent entity (1956).

Adler (1980) makes the distinction between selfobject transference and neurotic transference. In the latter case, a therapeutic alliance can be formed. According to Zetzel's aforementioned description, severely disturbed patients—namely, those with personality disorders marked by internal deficits—are often unable to develop a therapeutic alliance.

However, I believe an alliance can be constructed with these individuals, an alliance which is built by the clinician's assessment of the client's level of function and which meets their selfobject needs. Clinicians with certain characteristics, attitudes, and behaviors can maintain a connection with these individuals who present with vulnerabilities. These therapists' "real" qualities help make successful connections with these patients.

W.W. Meissner (1992) has written about the therapeutic alliance, differentiating it from transference and the real relationship. Meissner highlighted the importance of the therapeutic alliance, which begins with the first contact between patient and therapist. Meissner states, "The alliance not only comes into play, but it is being generated and shaped at every moment of the therapeutic interaction by both patient and therapist" (p. 4). Meissner believed that the alliance refers to the current relationship within the clinical dyad, unlike transference, which brings in others from one's past. The alliance is a necessary condition for effective treatment and offers a safe place for the patient to deal with intense affects and internal psychic experiences that develop within the transference (1992). Meissner listed various components of the therapeutic alliance and pointed out the role that both patient and clinician contribute to the bond. Factors that go into the development of this unique relationship include the following (1992):

1. Empathy…
2. Therapeutic framework…
3. Responsibility…
4. Authority…
5. Freedom…
6. Trust…

7. Autonomy…
8. Initiative…
9. Ethics…

Various characteristics, behaviors, and attitudes of both the clinician and patient inform these components, but this dissertation focuses on the clinician.

Meissner (1992) acknowledged the difficulty that practitioners have had in distinguishing the therapeutic alliance from the real relationship. According to Meissner, the practicalities of treatment include: setting, time, frequency, fee, the environment of the therapy office, as well as the practical situation of the patient. These "real" factors influence the therapeutic relationship (1992). Meissner noted that the real qualities of the analyst's person encompass the real relationship. These qualities contribute to the alliance and they include attitudes toward the patient, prejudices, moral and political views, and personal beliefs and values.

Adler described a "real relationship" with the analyst involving the patient's ". . . perception of the objective attributes of the analyst as they are distinguished from trans-transference" (1980, p. 548). This "real relationship" refers to the way the analyst uses personal qualities such as warmth and acceptance to relate to the patient. Perhaps understanding how the "real relationship" contributes to the alliance would enhance study of the clinician's role in "missed appointment phenomena." Can the clinician's role enhance it? Does it help motivate the patient to want to participate in the work of therapy? Is it necessary for the development of the therapeutic alliance, or for the effectiveness of the alliance?

Dewald wrote:

> An appreciation of the therapeutic power of psychoanalysis requires that we emphasize that at the height of the patient's regressive transference experiences there occur

> simultaneously and as part of the transference neurosis a large variety of "real" experiences perceived by the patient in relationship to the analyst's externally observed behavior (1976, p. 3).

Dewald said that a patient reacts to these "real experiences" at the level of his therapeutic regression and related experiences ". . . represent new and at times first experiences in response to the perceived reality of the analyst's behavior and reactions" (p. 3). Additionally, these instances are not transferences as repetitions of past experiences.

Sandor Ferenczi (1955) spoke of the person of the analyst in this way:

> I may remind you that patients do not react to theatrical phrases, but only to real sincere sympathy. Whether they recognize the truth by the intonation or colour of our voice or by the words we use or in some other way, I cannot tell. In any case they show a remarkable, almost clairvoyant knowledge about the thoughts and emotions that go on in their analyst's mind. To deceive a patient in this respect seems to be hardly possible and if one tries to do so, it leads only to bad consequences (p. 61).

In 1962 Max Gitelson wrote about the beginning phases of psychoanalytic treatment that lay the foundation for the therapeutic alliance, a necessary condition for effective psychoanalysis. Gitelson likened the first phase of analysis as similar to the early ". . . 'more or less good' mother-child situation" (p. 4). A new chance at development is enabled through the "environmental matrix" (p. 5) provided by the analyst / mother. Gitleson stated that the analyst is responsible for drawing in the patient, encouraging engagement in the analytic process.

Writing about the therapeutic relationship with children, Anna Freud (1980) discussed the importance of the treatment alliance:

> The treatment alliance also relies on the patient's feelings of trust, on the pleasure to be obtained from talking to someone and on the satisfaction gained from the therapeutic work, all of which reinforce the patient's cooperation. A warm and positive feeling toward the therapist also arises because of the therapist's contribution to being able to understand and put into words something that has bothered the patient, and this feeling too is not transference proper. The therapist is liked for having helped (1980, p. 48) .

Anna Freud also spoke about the qualities of the child therapist, saying, ". . . her person and her personal characteristics may be or more therapeutic importance than is generally realized" (1980, p. 50).

The concept of countertransference was initially described by Sigmund Freud (Heimann, 1950) and elaborated further by many others. Whether one considers countertransference negative or a positive aspect of treatment, the therapist must be aware of their internal feelings. As Heimann (1950) has written, "My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work" (p. 2). Racker, who categorized the ideas of concordant and complementary countertransference, wrote, "If (the analyst) fails to be aware of this reaction, his behavior will inevitably be affected by it, and he will renew the situations that, to a greater or lesser degree, helped to establish the analysand's neurosis" (1968, p. 138).

Relational theorist and psychoanalyst, Stephen A. Mitchell (1988) proposed a "relational-conflict model" which followed Freud's "drive-theory" model, and the developmental-arrest model. Mitchell wrote, "In the relational model, biology and interpersonal processes constitute perpetual cycles of mutual influence" (1988, p. 4). He also stated "In the relational

model, biology and interpersonal processes constitute perpetual cycles of mutual influence" (p. 4).

David Scharff attributed the origins of object-relations theories to Ronald Fairbairn and Melanie Klein, but noted that, "The notion of 'object relations' originated with Freud's discussion of the fate of the sexual instinct, libido, seeking an object or person by which to be gratified" (1996, p. 3). Stephen A. Mitchell (1988) pointed out that ". . . many of Freud's clinical insights *can* be disentangled from drive-theory metapsychology and *translated,* recast within the context of a relational matrix" (1988, p. 8). Mitchell also said, "Freud opened hitherto unexplored paths that allowed the exploration of unconscious processes, identifications and powerful conflictual passions within dyadic and triangular familial constellations" (1988, p. 8).

As pointed out earlier in the literature review, Freud had personal relationships with clients such as the Rat Man, and his impersonal relationship with Dora may indeed have prompted her to leave treatment. My study emphasizes the relational aspects of psychotherapeutic treatment to highlight the impact that clinicians believe they can have in client work. This includes influencing whether clients keep appointments.

The relational theorist and psychoanalyst Irwin Hoffman (1983) criticized the "blank screen" concept of psychoanalysis and disagreed with other analysts who dichotomize transference and non-transference aspects of the analytic relationship. Hoffman believes that personal qualities and aspects of the analyst are not separate from transference. The therapeutic process is intimately intertwined with transference responses. As Hoffman (1983) indicated, similar ideas about the analytic relationship come from psychoanalytic writers including Merton Gill, Heinrich Racker, Paula Heimann, Joseph Sandler, Lucia Tower,

Levenson, Issacharoff, Feiner, Ehrenberg, Harold Searles, and Paul Wachter (See p. 11 Hoffman, 1983).

As a social constructivist, Hoffman believes that reality is perpetually being constructed and is not pre-established or absolute (Hoffman, 1983). Hoffman wrote, "What the patient's transference accounts for is not a distortion of reality but a selective attention and sensitivity to certain facets of the analyst's highly ambiguous response to the patient in the analysis" (p. 14). The patient has been instrumental in creating countertransferential reactions within the analyst. Furthermore, the analyst's countertransference—and how it is dealt with in the therapeutic exchange—plays a critical role in helping the patient internalize a new way of social relating that differs from the past.

Hoffman mentions that there is ". . . a certain thread of transference-countertransference enactment throughout the analysis which stands in a kind of dialectic relationship with the process by which this enactment, as experienced by the patient, is analyzed" (1993, p. 19). Hoffman's 1983 paper, "The Patient as Interpreter of the Analyst's Experience" describes how this dialectic happens. In citing Hoffman, I emphasize that analysis and therapy are deeply relational, and that the clinician's self-awareness and skill play a vital role in helping the patient move forward in the therapeutic endeavor.

In "Affective Response of the Analyst to the Patient's Communications," Pearl King (1978) wrote the following:

> I define this affective response of the analyst as the perception by the analyst of feelings and moods, unrelated to his personal life, and which may even feel alien to his normal way of reacting, but which when placed in the context of the patient's material and the psychoanalytical setting, illumine and render meaning to those transference phenomena

> that are in the process of being experienced, consciously or unconsciously, by the patient. These feelings can often enable the analyst to perceive more clearly other dimensions of affective conflicts that the patient is consciously or unconsciously concerned with, the subtleties of which might otherwise have been lost to both patient and analyst. (1978, pp. 330-331).

Via self-awareness, the clinician can guide responses and enhance the therapeutic alliance. This self-awareness, a personal quality of the clinician, is critical in the work of therapy. Understanding the relationship between therapist and client may help to explain, at least in part, the missed-appointment phenomenon. The real relationship—generated by the therapist's personal qualities, characteristics, attitudes, and behaviors—affects the alliance. Some researchers, like Meissner, believe that the alliance is equally important as transference in affecting the outcome of treatment (Meissner, 1992).

Bordin (1979) reformulated the idea of the working alliance as described by psychoanalysts and applied it to a variety of helping relationships (Horvath and Greenberg, 1989). Bordin's ideas included the interdependence of the client and counselor as critical in the working alliance. Bordin also coined three concepts—(a) bond, (b) task, and (c) goal—as fundamental in this alliance (1979).

Contemporary psychoanalysts such as Jeremy Safran (2003) have written that patients in psychoanalysis improve due to factors in the analytic relationship that cut across different forms of therapy. Safran wrote:

> Over and above the immediate benefit of negotiating the type of alliance that permits the patient and therapist to collaborate constructively on specific therapeutic tasks or goals,

> the process of negotiation in and of itself lies at the heart of the therapeutic process. (2003, p. 7)

"Negotiation" refers to the process in which therapist and client agree on the purpose of treatment and goals. The therapist's ability to negotiate with the client demonstrates respect for the client, as well as flexibility in working with the client toward agreed-upon goals. Negotiation involves not only the real relationship between therapist and client but also aspects of the therapeutic alliance, which the therapist helps to build through negotiation. The recognition of the importance of negotiation and the ability to do so with the client can be considered one of the "attitudes" or "behaviors" of the clinician that this study hopes to understand.

Charles Gelso and his colleagues from the University of Maryland have studied the notion of the "real relationship" in psychotherapy and define it as follows:

> . . . the personal relationship marked by the extent to which the participants are genuine with each other and perceive and experience the other in ways that fit the other as well as by the magnitude of these behaviors, perceptions, and experiences and the extent to which they are positively versus negatively valenced. The strong real relationship possesses high magnitudes of genuineness and realism as well as positively valenced feelings and attitudes within the context of such realism and genuineness (2009, p. 255).

The person of the therapist is important in understanding the therapeutic dynamic. As discussed in Norcross (2010), the Task Force on Evidence-Based Therapy Relationships of the American Psychological Association (http://societyfor therapy.org/evidence-based-therapy-relationships) made the following conclusion:

> The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment. The therapy relationship accounts for why clients improve (or fail to improve) at least as much as the particular treatment method. Practice and treatment guidelines should explicitly address therapist behaviors and qualities that promote a facilitative therapy relationship . . . " (Norcross, 2010).

In *The Therapist as a Person: Life Crises, Life Choices, Life Experiences, and Their Effects on Treatment,* Barbara Gerson (1996) presented stories of therapists who describe the impact of life experiences on client work. As Gerson mentions, the work of many relational theorists highlight the importance of the analyst in the treatment process (1996). This paper does not explore this concept in-depth, but will touch on it in relation to the work of Irwin Hoffman.

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Social Work and the "Relationship"

This paper has cited references to psychoanalytically based treatment. While treatment processes may differ among clinicians of various schools of therapy, the foundation of any clinical work rests on the nature of the therapeutic relationship and its components, independent of different techniques. Social work has traditionally focused on the importance of the relationship with the client. As Goldstein states:

> In assuming his or her role, the social worker surely is an expert about many things that need to be known or provided; the client, however, remains the expert about his or her reality, which includes the beliefs, values, culture, goals, and other subjective factors that give life meaning and purpose. In effect, these 'experts' (literally, client and worker;

> metaphorically, author and editor or actor and director) join in a collaborative endeavor within a life in process to unravel awareness and the means of confronting certain problems of living (Goldstein, 1990, p. 38).

In a study of the development of the knowledge base of social-work practice and after a review of the literature, Goldstein (1990) concluded that:

> The optimal therapeutic relationship is one that is marked by collaboration, the sharing of initiative and responsibility, and the avoidance of dependency and authority. Concern with feelings, the therapist's self-investment, affirmations, genuineness, and empathy also contribute to the quality of the helping relationship. (1990, p. 37)

Following the social uprisings of the 1960s, Helen Harris Perlman (1979) wrote of a resurging emphasis on the clinical relationship. Perlman listed the following qualities of experienced clinicians as positive influences in relationship development:

1. Warmth…
2. Acceptance…
3. Empathy…
4. Caring-concern…
5. Genuineness…

In considering the social work / clinician side of the relationship, Pincus and Manahan (1973) wrote, "A social worker brings to his practice his own personality, values, life style, and feelings about other people along with his knowledge and skills. If he denies his own feelings, he may come across as a mechanistic technician and will have difficulty in engaging other people in problem-solving efforts" (p. 35).

Coady and Wolgien (1996) pointed out that the therapeutic alliance has evolved to indicate the interaction of therapist characteristics and behaviors with client characteristics and behaviors. The combination determines the quality of the relationship.

Some of the attributes of social workers in relationships, according to the social-work literature, are the same or similar to those in analytic literature. As social workers, we need to remember this as we think and work within a psychodynamic frame of reference. Our social-work heritage is very much in sync with some basic psychoanalytic principles.

Coady and Wolgien (1996) discussed a small qualitative study that examined the clinician side of the relationship. The study included therapists, including five social workers. Participants were asked what therapy activities helped their clients. Five major themes developed from this study (p. 316):

1. Exhibit Personal / Professional Qualities of Self…
2. Emphasize Development of Therapeutic Relationship…
3. Focus on Client Empowerment…
4. Attend to Impact of Self…
5. Apply Therapeutic Strategies / Interventions…

Participants believed activities and behaviors that enhance the therapeutic alliance were most helpful to their clients. Today's clinical social-work literature continues to promote the primacy of the therapist's use of self in the treatment relationship. Some researchers now advocate for an integration of the personal and professional selves (Edwards & Bess, 1998). These practitioners recommended (a) taking an inventory of self, (b) developing self-knowledge, and (c) accepting risks to self. Edwards and Bess strongly recommended that clinicians enter into their own psychotherapy to enhance self-awareness and self-

understanding (1998).

In his doctoral research on the impact of personal therapy on clinical social workers' practice, Robert Mardirossian (1993) found that the clients he studied ". . . were quick to point out that the specific discipline or theoretical orientation of their therapists was less consequential for their treatment outcome than the manner in which their therapists related to them" (pp. 122-123).

Stephen Mitchell, cited earlier, emphasized the role of the relationship, and how therapist and patient influence each other (Ganzer, 2007, citing Mitchell, 1988). Ganzer illustrated a relational perspective in this way:

> It is by the therapist and patient working through and reflecting on enactments that involve therapist's and patient's transference and countertransference transactions that a space is created for new patterns of interaction to develop. The therapist's use of self then becomes an interactive, subjective, and empathic means of furthering therapeutic action and portending a positive outcome to the treatment (p. 119).

A 2007 position paper representing the views of the Clinical Social Work Association laid out essential elements of clinical social work and recommendations for social-work education (Simpson, Williams, & Segall, 2007). The paper highlights two key principles of clinical social work: ". . . the person-in-situation perspective and the concept of relationship" (p. 3). The following statement clearly points to the critical place that relationship plays in clinical social work:

> The concept of relationship is as old as time. Everyone has an experiential understanding on it. This paper defines relationship as the dynamic connection between two or more people. It is a process involving transactions among intra-psychic, interpersonal and

> sociocultural systems. Relationship is not only the context for development, but also the principal tool of social work intervention (2007, p. 5).

These ideas underscore the purpose of the current study, which is that the missed appointment constitutes a behavioral response that is part of a conversation between the therapist and patient. This study suggests that a combination of certain attributes and behaviors facilitate the treatment relationship. When the therapist fails to connect via words, tone, and affective communications, the patient is more likely to act out by not attending and rejecting the therapist as a means of problem-solving. This is true despite the given reasons for missing. With this understanding, we can do something to curtail the failure rate of treatment and the extent of missed appointments. This study has attempted to ascertain clinicians' views on the subject.

Research and the Alliance

Much has been written about the unique relationship between therapist and client. This literature review does not provide an extensive summary of study on the therapeutic alliance. However, a sampling of studies returns some common findings.

A study conducted by Lester Luborsky, Ph.D. (1976) reported the results of the Penn Psychotherapy Project, which studied 73 patients and rated the 10 who made the most improvement and the 10 who made the least improvement. The most significant finding was that patients who improved the most showed evidence of the development of a helpful, supportive relationship early in treatment.

Hill and others measured the effect of how therapists and clients perceive each other's covert processes in long-term therapy (Hill et al., 1993). The researchers assumed that the more open and honest the client, and the more transparently the therapist communicates intentions, the more a solid therapeutic alliance can develop. The findings revealed that clients did not reveal negative thoughts and feelings. Some had secrets that they kept from their therapist. In addition, therapists were often unaware of things the client was not saying or how they might be reacting (1993). The research pointed out the therapist's key influence in conveying to the client what is permissible to talk about in therapy. The researchers recommended further studies to discover how therapists encourage clients to reveal (a) negative feelings, (b) secrets, and (c) thoughts they are ashamed of, as well as methods of dealing with shameful feelings that clients tend to keep to themselves (1993).

Horvath and Symonds (1991) conducted a meta-analysis of 24 studies relating the quality of the working alliance to outcome. The data from this research consisted of studies conducted over a period of 11 years. While the research did not specifically address drop-outs from treatment, it assumed that those who leave treatment prematurely and without discussion with the therapist lack a positive therapeutic alliance. Results showed that the quality of the working alliance was most predictive of the therapeutic outcome based first on clients' assessments, then on therapists' assessments, and lastly on observers' reports.

These findings were not related to the type of therapy practiced or the length in treatment. The definition of "outcome" included, "The client's observed pro-social behavior forming a useful positive relationship with the therapist, engaging in the therapeutic tasks, collaborating with setting realistic goals . . ." (p. 9). The goal of this dissertation was to discover factors that clinicians believe impact clients' engagement with and ongoing attendance in therapy.

This goal acknowledges that for some clients, therapy can be confusing, frightening, or misunderstood.

Another study conducted at a counseling center at Fordham University (Tryon & Kane, 1993) attempted to determine the relationship between unilateral termination and the strength of the working alliance. Participants were 103 college students who sought help for personal problems at a college counseling center. The therapists included four Ph.D. psychologists and six psychotherapy practicum trainees. After the third research session, all participants received the short version of Horvath and Greenberg's Working Alliance Inventory (1989). Results showed that the counselors' assessment of the strength of the working alliance predicted the type of termination (1993). The implications place considerable weight on the counselor's assessment of the working alliance as a factor in the client continuing therapy. If the therapist views problems in the working alliance, he or she can work on strengthening the relationship (1993). The counselor can have an impact on improving the working alliance to prevent unilateral termination from treatment.

A small study in 1994 (Castonguay et al., 1996) measured three variables on outcome measures of 30 clients engaged in cognitive therapy. The variables were (a) the effect of the therapeutic alliance, (b) "client experiencing," and (c) the therapist's emphasis on how distorted thoughts affect depressive symptoms. The findings revealed that the therapeutic alliance and client experiencing were positively related to improvement. However, some therapists' strict focus on cognitive treatment techniques were negatively related to improvement. According to the researchers, when the therapist tried to convince the client about the benefits of cognitive treatment, and there were issues in the alliance, the therapeutic

alliance worsened. Also, when technique took precedence over the alliance, the treatment suffered.

Attention to variables among therapists and their effect on treatment has also been written about during the last 20 years. Findings have been inconclusive and contradictory in some of these studies (Beutler et al., 1994). However, there has been concerted effort to understand the person of the clinician and related effects on the alliance.

Recently, many practitioners have supported the importance of the therapeutic alliance, suggesting that change occurs via a combination of (a) therapist technique, (b) client variables, and (c) the therapeutic relationship (Hill, 2005; Golfried & Davila, 2005). Hill proposed separation within these three aspects of the treatment, stating, "I suggest that it is better to assess each variable separately to get a more accurate assessment of what is going on in the process. Only then can we assess the interaction among the variables" (p. 440).

My study highlights one of these variables by focusing on clinician qualities, characteristics, attitudes, and behavior within the therapeutic relationship, as described by the clinicians. A few studies have been directed at therapist attitudes and the effect on treatment outcome. A 2004 study by Falconnier showed that therapist attitudes toward clients with lower socioeconomic status affected outcome. Falconnier suggested that therapists examine their own stereotypes about lower-socioeconomic clients, especially because the researcher found no correlation between socioeconomic status and attrition (2004). Here we see some attention to therapist attitudes affecting the therapy process.

Hersoug and others (2009) studied therapist characteristics in relation to the development of the working alliance in long-term therapies. Therapists rated themselves and clients rated their therapists. Therapists with a distant or indifferent interpersonal style received the lowest

ratings from both therapists and clients. A greater degree of professional training was negatively correlated with higher patient ratings of the alliance. This study revealed that therapists' degree of interest and warmth positively affects the working alliance.

There is consistency in reports about the critical nature of the therapeutic relationship. McCabe and Priebe (2004) produced a literature review of all studies that used specific measurement tools in assessing the therapeutic relationship. Fifteen measures were examined, with various scales measuring client and therapist contributions to the relationship. The study concluded that the nature of the therapeutic relationship is a reliable predictor of outcome in mainstream psychiatric settings (2004).

The same study also found that clinician efforts to address client defenses and negative feelings in relation to the therapist differentiated positive and negative outcomes (McCabe & Priebe, 2004, citing Foreman & Marmar, 1985). Attending to troublesome features in the helping relationship can positively affect outcomes. My research has reported on clinicians' efforts to address or ignore missed appointments with the client.

Gelso and others (2009) developed measures of the real relationship in therapy in the form of two scales: RRI-C, the client measure of the Real Relationship Inventory, and RRI-T, the therapist measure of the Real Relationship Inventory. The researchers defined the strength of the real relationship as ". . . a combination of realism, genuineness, magnitude, and valence" (p. 258). The study found that, ". . . the therapist-rated real relationship predicted outcome in the form of symptom change above and beyond the variance accounted for by working alliance" (p. 258).

Research on Attendance

A good deal of research has focused on missed appointments and withdrawal from treatment. Many of the related studies cannot be accurately compared with each other because of the differences in (a) the populations sampled, (b) definitions of "adherence" and "dropouts," and (c) questions asked. However, it is interesting to note that this phenomenon has interested researchers for decades.

Barrett and others provided an extensive review of the literature that focused on drop-outs from treatment. The researchers maintained that the treatment withdrawal rate reaches 50% by the third session, with 35% ending therapy after the first session (Barrett et al., 2008, citing Affleck & Medwick, 1959; Hiler, 1958; Rogers, 1951; Brandt, 1965). This problem, according to the researchers, leads to long waiting lists and subsequent delays of treatment. It can also affect the morale of staff and become a financial loss to the clinic. The researchers note that their statistics on attrition are inexact because there are differences in the definition of "attrition."

From 1990 to 1992, Edlund (2002) and others conducted an epidemiological survey on treatment dropouts, with "dropouts" defined as those who left treatment prior to the twenty-sixth visit for reasons other than symptom improvement. This research revealed that no significant difference existed in the dropout rate for United States respondents and those in Ontario. In addition, no significant difference existed between dropout rates in the two locations due to diagnosis or specific sociodemographic characteristics such as:

1. Country of residence…
2. Income…
3. Urbanity…

4. Gender…
5. Education…
6. Race…

Those without insurance and young people had the highest dropout rates. Those who were seeing a spiritual advisor (as opposed to other types of providers) had a significantly higher rate. Settings that provided dual modality treatments, such as talk therapy and medication management, had a lower rate. The rate was higher for clients with negative attitudes toward mental-health treatment. The findings revealed that approximately 10% of patients in both the United States and Ontario dropped out by the fifth visit, 18% by the tenth visit, and 20% by the twenty-fifth visit. These findings reveal much lower rates than the studies cited by Barrett and others. However, it appears that certain sociodemographic factors, sometimes thought of as issues leading to a high drop-out rate, may not be so critical.

Reis and Brown (1999) summarized 30 years of research on drop-outs from therapy. They looked at client, therapist, and administrative variables and discovered contradictory findings in the literature. However, the following factors were attributable to most treatments not characterized by "unilateral termination": (a) therapists' attempts to work with different perspectives that clients may bring, i.e., "perspective convergence in the psychotherapy dyad," (b) efforts at preparing clients for therapy, and (c) an ability to see clients as partners in the treatment. These factors can reduce the frequency of unilateral termination (1999). Here we see concepts of "negotiation" and "empathy" as playing a role in client retention.

In 1976, Saltzman and others tried to predict clients' involvement in therapy and tendency to continue with treatment. The researchers measured a sample of clients and therapists on traits including:

1. Respect…
2. Understanding…
3. Openness…
4. Continuity…

These measures were obtained by self-report of both clients and therapists. The study found that three-fourths of dropouts occurred before the sixth session. In addition, a strong relationship existed between third-session dimension scores and remaining in treatment. The researchers determined that by the third session, the development and nature of the therapeutic alliance can play a predictive role in determining drop-outs.

In this study, Saltzman and company also looked at *what* clients experience in therapy as well as *when* they experience it (i.e., early in the treatment) as factors influencing drop-outs. Additionally, therapist experience and client-therapist gender similarity proved insignificant. The researchers reached this conclusion:

> Briefly, the results of this study point to the crucial importance of the following specific patterns of interaction during the initial phase of treatment. First, the anxious and active appeal for help on the part of the client must evoke a strong sense of involvement on the part of the therapist. Second, beyond the initial session, the therapist must remain involved and the client must view the therapist as competent and committed. Third, client and therapist must develop a mutual respect and shared sense of the continuity of their relationship (p. 553).

Also, the researchers reported the following:

> The first to dropout are those who experience relatively lower levels of anxiety. This group may include those with strong defenses against anxiety and those seeking

> alloplastic solutions, as well as the highly apathetic. The next, and largest group of dropouts, in reporting their experience during the third session focused on the therapeutic interactions and reflected widespread dissatisfaction with it. (p. 552)

Another large study (Wang et al., 2000) involved 14 mental-health advocacy groups in 11 countries. Researchers mailed surveys to 3,516 individuals. Conclusions of the study indicated that the following factors were significant in encouraging participants to initiate and continue in treatment: (a) patient's knowledge and awareness of mental disorders and treatments, (b) clinician skill in educating the patient about diagnoses, treatments, and side effects, and (c) side effects from treatment and insurance coverage (2000). The study also found that the most common reasons for dropping out were "feeling better" and "wanting to handle things on one's own." Additionally, researchers stated, "Clinicians must anticipate these reasons for dropout when communicating with their patients and emphasize the necessity of remaining in treatment throughout the acute and continuation phases to prevent relapse" (p. 6). Factors of the relationship were not teased out. However, the importance of the therapist educating the patient about treatment is important. A clinician taking the time to explain things to a client reflects the clinician's interest in the patient, which is a relationship factor.

Romeria Tidwell (2004). conducted a 1996 exploratory study on no-shows among African American female clients at an urban health-care center. A psychologist telephoned 90 women who had missed appointments. These women comprised two groups: those who had missed mental-health appointments and those who had missed medical appointments.

Tidwell found that reasons for missing appointments differed significantly between the groups. Those who missed medical appointments said they forgot about the appointment or

missed because of scheduling errors. Those who missed mental-health appointments cited environmental factors or various practical reasons. Since both types of appointments occurred in the same institutional setting, one can interpret the differences as correlating to the types of treatment offered. Tidwell concluded: “This exploratory study found some evidence for associating the concept of resistance [to mental health treatment] with the missed appointment behavior of African American female patience” (p. 10).

In a study of evaluation of alliance-focused interventions for potential treatment failures, Muran and others (2005) found that dropout rates were lowest among the group of patients treated with brief relational therapy (BRT), as opposed to those treated with cognitive behavioral therapy (CBT) or short-term dynamic psychotherapy (STDP). The study included 128 participants. Data were collected over an eight-year period from 1992 to 2000. “Dropout rate” was defined as the termination of treatment before the completion of 30 contracted sessions. Each dropout was unilaterally determined by the patient. Analysis of dropout rates among the three treatment groups showed significant differences. Forty-six percent of patients dropped out from the STDP treatment protocol, 37% from CBT, and 20% from BRT. Brief Relational Therapy is described below by Muran and company.

> Its primary task is to track alliance ruptures and engage the patient in a process of meta-
> communication (e.g., establish a communication about the communication process) in order to bring awareness to bear on what is going on unwittingly in the therapeutic relationship (in other words, on the implicit negotiation between patient and therapist in
> regard to their respective needs). BRT is based on a social constructionist model of the

> therapeutic relationship, whereby ruptures and their resolution are understood as co-participatory processes involving both patient and therapist. (Muran et al., 2005, p. 6)

According to the researchers, the BRT model brings together principles of relational psychoanalysis and humanistic psychotherapy.

Johansson and Eklund (2005) conducted a study to determine which client factors contribute to dropout from treatment. A sample of 122 patients who attended an outpatient clinic in Sweden answered a series of questionnaires over a five-month period. Staff answered questions about the helping alliance. The patients answered questions about motivation, symptoms and interpersonal problems. The researchers concluded: "The most important client factors for establishing helping alliance and for predicting early dropout seem to be those relevant to interpersonal processes" (p. 140).

In writing about work with poor clients, Schnitzer (1996) advised clinicians not to label clients as uncooperative when they miss appointments:

> We stand a better chance of doing meaningful work with our poorest clients if we can open ourselves to the possibility of change--not only in accessibility of services but in the therapeutic interactions themselves. In the conversations that promote caring, social and economic conditions must be recognized for the crucial roles they play, the overwhelming impact they make (p. 581).

Efforts to Reduce the No-Show Rate

A study at the Memorial Hermann Texas Medical Center and the UT Medical School at Houston (Gajwani, 2014) aimed to reduce the no-show rate among chronically mentally-ill patients at an academic psychiatric clinic. The results indicated that operational changes in

the organization reduced the no-show rate, but that the changes needed to be maintained to continue the positive results. The success of the project depended on changes including:

1. Making personalized reminder calls…
2. Informing clients of the termination policy after three consecutive no-shows…
3. Engaging cooperation of all team members in enforcing the new changes…
4. Receiving support from the department chair and the administration…

Long and others tested an intervention to reduce missed appointments at a university psychiatric clinic in Tennessee (Long et al., 2016). These researchers cited Mitchell and Selmes (2007a), who reported that nonattendance rates at outpatient psychiatrics clinics are between 12% and 60%, and that the rate for the initial appointment in psychiatric clinics is twice that of other specialties. Long and others collected data from March 2011 through September 2012. Their approach involved a patient-centered scheduling intervention that focused on the quality of the relationship between the scheduler and prospective client and respected the client's preferences and needs. It also involved (a) making phone calls within 48 hours of the scheduled appointment, (b) offering flexible appointment times, and (c) mailing clinic information prior to appointments. The researchers emphasized accommodating the client first, instead of the clinician. Show rates for first-time appointments increased after this intervention.

Filippidou and others conducted a project in Great Britain (2014) to reduce the missed-appointment rate by using text messaging to remind clients of their appointments. After introducing this intervention, the researchers reported a reduction in missed appointments.

In the Netherlands, a team of researchers—Van, Dieren, Rickmans, Mathijssen, Lobbestael, and Arntz—conducted a 2013 study, finding that implementation of a no-show

policy reduced no-show rates from 21.5% to 14.6%. Clients in this study included young people aged 16 to 25 years. The no-show policy consisted of a 20-minute appointment scheduled after the no-show appointment, in which the reason for the missed appointment was discussed and a decision was made to continue or stop treatment. If a client failed to show for this 20-minute appointment (except for exceptions discussed in a multi-disciplinary team meeting), the case was terminated.

In most of the studies cited in this dissertation, relational factors seem to influence continuance in treatment. As earlier stated, the therapeutic alliance is critical to a sound treatment environment. The therapist carries much responsibility in building this alliance. The therapist's effort, understanding, and relational qualities help to build the therapeutic foundation. The therapist can strengthen the foundation of the therapeutic endeavor by educating patients about the treatment and what to expect, and demonstrating a desire to understand the patient's issues within contexts including ethnicity and socioeconomic status. However, few studies specifically describe how clinicians experience and understand their impact on clients' missing appointments.

Theoretical and Conceptual Framework

The researcher used various aspects of psychoanalytic theory to frame and interpret the results of this study. To understand research results, the researcher highlighted this concept: The dynamic unconscious is operational in all aspects of human behavior. Additional concepts that helped frame study results include:

1. Transference…

2. Countertransference…
3. The "holding environment"…
4. Object-relations theory…
5. Recent thinking about relational concepts…

Whatever strain of psychoanalytic theory to which one adheres, the concept of relationship is at the core of the specific school of thought.

Research Question

This study sought to answer several questions:

1. What do clinicians in outpatient psychiatric clinics think about their impact on missed appointments?
2. Do therapists feel they can influence patients' attendance at sessions?
3. What, if any, characteristic, qualities, behaviors, and attitudes of the clinician contribute to a positive therapeutic alliance?
4. How do those same traits impact a client's compliance with treatment, as understood by the clinician?

To answer these questions, the researcher asked clinicians about their experience with missed appointments, specifically (a) how they understand the missed appointment, (b) how they feel toward the client, and (c) how they handle it. They were also asked about their practice in general and what they enjoy and don't enjoy. In addition, the researcher utilized several objective measures to obtain basic data about the clinicians.

Theoretical and Operational Definitions of Major Concepts

This study seeks to find out what clinicians think about their impact on missed appointments. Major concepts involved in this study are as follows.

Missed appointment.

A scheduled appointment in which the patient fails to show by not coming or by not canceling within 24 hours before the appointment.

Therapeutic alliance / working alliance.

"Cooperation and collaboration in the therapeutic process" (Moore and Fine, 1990, p. 196).

Real relationship.

The qualities and behaviors which pertain to the therapeutic pair as real individuals (Moore & Fine, 1990, p. 195).

Transference.

"Displacement of patterns of feelings, thoughts, and behavior, originally experienced in relation to significant figures during childhood, onto a person involved in a current interpersonal relationship" (Moore & Fine, 1990, p. 195).

Countertransference.

"A situation in which an analyst's feelings and attitudes toward a patient are derived from earlier situations in the analyst's life that have been displaced onto the patient" (Moore & Fine, 1990, p. 47).

Transference and countertransference.

The social-constructivist paradigm replaces these concepts with the notice of subjectivity in the analytic situation. "The notion of interaction on multiple levels gives full meaning to the idea of participation in the analytic situation" (Hoffman, 2002, p. 41). Exchanges formerly thought of as transference and countertransference are now exchanges of real, personal qualities of each participant.

Negotiation

The process between therapist and client in which the purpose of treatment and goals are mutually agreed upon. (Safran, 2003).

Statement of Assumptions

1. The clinician or therapist plays an important role in the frequency of missed appointments and retention of clients in outpatient psychiatric clinics.
2. The clinicians interviewed will be able to articulate some factors that they perceive to contribute to clients' ongoing compliance with scheduled appointments.
3. The methodology will elicit clinicians' opinions about factors contributing to their clients' missed appointments, including those attitudes and behaviors in the clinician which they feel are significant in affecting the show rate of clients. Interviewing patients themselves while they are in treatment would have the potential to disrupt the therapeutic relationship, may not yield accurate data, and may negatively affect the therapeutic enterprise.
4. The research interview is co-constructed and material which surfaces comes from the clinicians as well as from the interactive nature of the research relationship. Both parties influence each other.
5. We don't always know what lies behind one's actions. All qualitative research tries to understand the spoken as well as unspoken word. Attitudes, behaviors, and qualities of clinicians will be extrapolated from a detailed study of the data, with attention paid to non-verbal communication. Memos and notes by the researcher will attempt to discover non-verbal information as the data are analyzed.
6. How clinicians view their impact in retaining clients can be important in understanding the missed appointment phenomenon in outpatient psychiatric clinics.

Chapter III

Methodology

Philosophical Underpinnings of the Research Methodology

During the past several decades, research in the social sciences has undergone changes in form and design. Early researchers were expected to follow the "scientific" method, meaning objective and rational measures (Anastas, 2012, citing Kahn, in Polansky, 1960). This method included "scientific" rationale and an emphasis on descriptive, explanatory, and exploratory research. Prior to modernity, Immanuel Kant argued for "enlightenment," meaning ". . . man's release from his self-incurred tutelage" (Kant, I. (1784) In (Waugh, 1992, p. 90). Kant stressed the importance of the individual using reason to solve problems without relying on the guidance of others. Humans should not be wildly free, but should instead feel free to express opinions and ideas publicly while privately abiding by the law.

What follows are some brief comments on the evolution of the postmodern position. Ken Wilbur (1998) describes the changes in our world across eras, from pre-modern to modern to postmodern. Wilbur believes that postmodernism is a revolt against the primacy to which science rose and its exclusion of morals and the subject. Further, Wilbur describes postmodernism as characterized by the following beliefs: (a) reality is partly constructed, (b)

meaning is context-dependent, and (c) knowledge should not be limited to one perspective. From this viewpoint, interpretation becomes central to epistemology and being.

Postmodernism reflects a shift from the modern movement of the late nineteenth and mid-twentieth centuries. Instead of common social narratives, culture and the social world are viewed in terms of multiple viewpoints. In addition, one sees the primacy of "subjectivity" and an abandonment of absolute truth, the ideological and the metaphysical (Jameson in Drolet, 2004, pp. 121-124). Jean-Francois Lyotard described postmodern as "incredulity toward metanarratives" (1984). Postmodern thinking has influenced art, culture, the social sciences, and other aspects of life today. Developments in psychoanalytic thinking and practice have been influenced by this philosophy and way of viewing the world. Social work research has also been influenced by postmodern epistemology. This study, using constructivist grounded theory, is an example of a postmodern approach to research.

Postmodern ideas are reflected in interpretive qualitative research. Quantitative research was a commonly used method in the social sciences until postmodern ideas began to take hold. As Glaser and Strauss (2008) describe, the social sciences gradually began to develop theory and not just verify grand theories, as had been the practice in modernism. Grounded theory evolves from data. Categories and properties of categories are identified and comparisons made between categories. The emergent theory evolves through an analytical process aimed at reflecting significant concepts and ideas. Denzin and Lincoln (2000) described qualitative research not to "find knowledge," but to construct meanings and interpretations of what we observe. The two researchers wrote:

> Qualitative research is a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that make the world visible.

> These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin and Lincoln, 2000, p. 3).

This kind of data collection and analysis employs constructivist grounded theory as described by Charmaz (2006).

Barney Glaser and Anselm Strauss (Charmaz, 2006) were the original developers of grounded-theory procedures and techniques. Strauss and Corbin (Charmaz, 2006) expanded the original ideas proposed by Glaser and Strauss. Charmaz moved grounded theory into a new realm of postmodern thinking that highlights facets including (a) context, (b) construction of data, and (c) analysis of the interaction between participant and researcher (Richards & Morse, 2007). Charmaz describes grounded theory as ". . . flexible, emergent" and says that during research, ". . . ideas and issues emerge during the interview, and interviewers can immediately pursue these leads" (2005).

Research Strategy

Recruitment of participants began when I approached an advocacy organization named Community Behavioral Health, of which my employer, University of Maryland Medical Center, is a member. I described my study to the president of the organization, who forwarded this information to providers. I also gave a presentation to the clinical committee of Community Behavioral Health. I received responses by email from two community

mental-health clinics in Maryland, indicating interest in my study. These clinics are in semi-rural areas of the state. I will refer to them as “Clinic A” and “Clinic B” to differentiate them in my discussion. I developed a Memorandum of Agreement with each clinic, which was signed by the directors of each organization. See Appendix B for recruitment materials, which I included in my submission to the institutional review board (IRB) at the Institute of Clinical Social Work (ICSW).

After the IRB at ICSW approved my research project, I needed to submit my project to the IRB at the University of Maryland Medical System, where I am employed. My employer required this step, even though this study was separate from my functions as an employee. The University of Maryland reviewed my proposal and my ICSW approval, and approved my project.

After obtaining approvals, I worked to develop an interview guide. I designed questions to elicit answers about how clinicians think about their impact on missed appointments in their clinics. The initial questions sought to establish a comfort level for participants and to place their responses within the larger context of their work functions. Open-ended, broad questions are recommended for qualitative studies (Creswell, 1994) because they allow participants to freely include their thoughts and ideas. Closed-ended questions, such as those used in quantitative research, do not invite those types of answers (1994).

Charmaz (2006, p. 26) states, “For a grounded theory study, devise a few broad, open-ended questions.” Charmaz suggests that researchers strike a balance between broad and semi-structured questions, and also recommends that researchers show interest in participant answers and seek to know more. “In your role as an interviewer,” Charmaz writes, “your comments and questions help the research participant to articulate his or her intentions and

meanings" (p. 26). I employed these practices, as described in the "Results" section of this paper. I revised the questionnaire after interviews at the first clinic site, to explore ideas that emerged during the first round of interviews. At the end of each interview at both clinics, each participant received a demographic questionnaire (see Appendix C).

I conducted interviews with 12 clinicians at two community psychiatric clinics located in Maryland. I originally proposed to interview approximately 15 social-work clinicians. However, given that other clinicians working in these facilities often include clinicians of other disciplines, the study included licensed professional counselors and psychologists. My dissertation chair approved this change.

Data Collection Process: Clinic A

To begin data collection, I contacted the director of Clinic A and met with him in person to describe my study. After that meeting, the director arranged for me to return to meet with a group of clinicians during one of their regularly scheduled meetings. I invited those clinicians to sign up for the study on sign-in sheets left in their clinic.

These sheets listed specific interview times. Interviews took place according to this schedule on several different days.

When meeting with each participant, I reviewed the nature of the study. Each participant signed an informed-consent form that described the purpose of the study, the procedures used in the study, benefits, costs, possible risks and/or side effects, privacy and confidentiality practices to be used during the study, a statement that they could withdraw from the study at any time, and list of people they could contact if they had questions about the study. These

included the principal researcher, Dissertation Chair/Sponsoring Faculty, and Chair of the Institutional IRB at ICSW.

This part of the research involved two different consent forms due to a change in the dissertation chair and IRB chair after I conducted interviews at Clinic A. Also, Clinic B staff wanted to receive an adjustment in their productivity for the month, which could only be done if their manager knew they had participated in the study. A new consent form was submitted to the IRB and approved. This form included a notation giving the researcher permission to inform site managers that participants had joined the study (see Appendix A).

Interviews lasted between 45 and 60 minutes. Interviews were audio-recorded, transcribed by the researcher, identified by a number, and kept locked during the study. The transcription process was very time-consuming, but it helped the researcher to immerse herself in the data while carefully listening to participants, recalling interviews on a visual level. The tone of participant voices helped capture nuances in their answers. Eight clinicians participated from Clinic A. All participants were eager to be interviewed and expressed interest in the study. Each participant received a small fee ($30.00) for participating. I decided this amount would help offset the time and fees lost during interviews.

Participants received interview transcriptions via email, along with a request for them to review for accuracy. This step established member-checking. Only two participants responded. One asked for a minor change, while the other asked me to omit a paragraph to protect her privacy. After this part of the data collection, I became ill and was unable to continue interviewing until the following year. Although I was unable to collect data during the months of my illness, I began initial coding of the Clinic A interviews. This process is described in the “Data Analysis” section below.

Data Collection Process: Clinic B

The data-collection process at Clinic B took time to initiate. I had difficulty connecting with the manager of this clinic, although he had previously signed a memorandum of agreement, allowing me to recruit research participants at his clinic. After multiple efforts, I finally received a positive response from the manager, inviting me to attend a scheduled staff meeting at Clinic B. At that meeting, I described my project and tried to recruit participants. Five therapists submitted their names and contact information. Later, one therapist withdrew her interest. I then began scheduling interviews at that clinic.

I modified the interview guide for research at this clinic, to follow up on some ideas that emerged in the initial round of interviews at Clinic A. (See the "Revised Interview Guide" in Appendix C.) These ideas included the possible effect of nonverbal behaviors on clients' missing appointments. Also, I wanted to discuss how clinicians experience the attitudes of management towards them and the work environment. Because participants at Clinic A had used the term "this population," I wanted more information as to what that phrase meant to them.

The interviewing process for Clinic B matched that of Clinic A, as described previously. Member checking was also performed. One person made some brief additional comments after the researcher contacted her as a follow-up to the initial interview. These participants also received $30.

Data Analysis

Analysis of the data began with coding. According to Charmaz (2006), coding helps the researcher describe what occurs in the data and search for its meaning. I purchased a qualitative research software program, Atlas.ti, to help with the coding process. I engaged in line-by-line initial coding for the first three interviews. I went through the material line-by-line and labeled short segments with names descriptive of the meaning of the segments. This is the process of open coding that Charmaz (2006) suggests. This coding returned 560 bits of data. I organized this information by looking for similar ideas, comparing data, and grouping them into specific codes, which I labeled.

I then proceeded to code the additional interviews using existing codes. I did this by assigning segments of data into the existing codes and adding new codes as information emerged from subsequent interviews. I also deleted some codes that did not accurately describe the meaning in the data and created new ones. Focused coding involves selecting the most significant earlier codes to categorize the data.

This is an active process, as described by Charmaz: "Through focused coding, you can move across interviews and observations and compare people's experiences, actions, and interpretations . . . A telling code that you constructed to fit one incident or statement might illuminate another (2006, p. 59). I collapsed the initial codes into fewer focused codes by reviewing the codes repeatedly and finding some central concepts that became higher-level conceptual categories.

The coding intended to capture ideas verbalized in interviews. The process focused on participant ideas about clinician impact on missed appointments. As I coded, I wrote comments and memos about (a) the codes, (b) participant answers, and (c) reflections. I also looked for ideas that occurred to me as participants answered questions. According to

Charmaz, memo-writing helps lift focused codes into conceptual categories and define properties of categories. This in turn reveals relationships among categories and gaps in the analysis (Charmaz, 2006).

> Memos catch your thoughts, capture the comparisons and connections you make, and crystallize questions and directions for you to pursue. Through conversing with yourself while memo-writing, ideas and insights arise during the act of writing. Putting things down on paper makes the work concrete and manageable—and exciting (Charmaz, 2006, p. 72).

Throughout the data-analysis process, I listened to interviews at different times to stay close to the data and continue to listen to the participants.

Because there was a break in my data collection due to illness, the data analysis for the interviews at Clinic B—as well as the overall data analysis—began a year later. I coded Clinic B interviews by using existing codes developed from the Clinic A interviews. I coded over and over, rethinking and comparing what I heard in the data. Charmaz (2006) advises researchers to code in terms of actions, instead of topics (2006). This took some practice on my part, but eventually I began thinking in terms of actions.

As I reflected on the data and the evolving codes, patterns began to develop. I started grouping existing codes into "clumps" (my term) or "families," to develop overarching categories. These categories contained subcategories, or properties of various categories.

I described how each family related to my research question. I reviewed the sub-categories to make sure they were properly included in the main category. Initially, there were six families and each had between six and 21 subcategories. I created categories that were more conceptual than the focused codes, which were not sufficiently abstract and could

not include similar ideas. I coded and recoded many times, gradually lifting the data into more abstract, conceptual categories that included ideas found in the codes and detailed data. I checked the codes I had developed to make sure they accurately included the meanings I wished them to have. The final categories were labelled in terms of actions and processes; for example, “Responding the Miss: Making Meaning” and “Laying the Foundation.”

The final categories had between three to eight subcategories and included the major ideas and meanings found in the data. During the data-analysis process, I drew various diagrams that depicted what I saw. This visual depiction helped me begin to ascertain relationships among the categories and to discern patterns.

How clinicians understood the meaning of a missed appointment appeared to factor into how they dealt with the client, regardless of whether the client returned. Clinicians had emotional reactions that also influenced how they dealt with a client who missed. To analyze this information, each interview was reviewed, looking for therapist’s thoughts, feelings, and subsequent behavior toward the client. My private notes listed therapists’ behavior in response to each situation. Some clinicians reached out immediately expressing concern. Others reminded the client that the case could be closed if the client didn’t come to appointments. Still other clinicians tried to explore the meaning of the miss with the client in a constructive way. Links between these categories were noted and interesting information was obtained.

Partway through the work of coding, my computer was attacked by ransomware and all my files were infected. However, I had arranged a back-up of my work so it was not lost. Nevertheless, I had to purchase a new computer and re-install the software into the new computer. This transition involved some technical problems that eventually worked out.

Chapter IV

Results

Table 1: Description of Participants Interviewed

Participant #	100	101	102	103	104	105
Degree/Certification	LGSW	LCSW-C	LGPC	LCSW-C	LCPC	LCSW-C
Years as Clinician	1-3 years	1-3 years	1-3 years	4-7 years	1-3 years	---
Time in Position	1-3 years	1-3 years	<1 year	4-7 years	1-3 years	---
Personal Therapy	No	Yes	Yes	Yes	Yes	---

Participant #	106	107	500	501	502	503
Degree/Certification	LCPC	LGSW	Psy.D.	Psy.D.	LCSW-C	LCPC
Years as Clinician	1-3 years	<1 year	4-7 years	8-15	15 years	20+ years

				years		
Time in Position	1-3 years	4-7 years	1-3 years	1-3 years	4-7 years	4-7 years
Personal Therapy	Yes	No	Yes	Yes	Yes	Yes

Of the participants, six were licensed social workers, four were licensed professional counselors, and two were doctoral-level psychologists. Additionally, one participant failed to complete the demographic questionnaire. The clinicians at Clinic A were fairly new to the clinic, averaging about two to three years, both at the clinic and in their careers as clinicians. The clinicians from Clinic B had been working as clinicians twice as many years as those at Clinic A. Only two clinicians had no prior personal-therapy experience. The diagnoses of individuals treated at both clinics consisted mostly of individuals with mood disorders and anxiety disorders, with only a small percentage of clients having psychotic disorders. I did not ask about clinicians' theoretical orientation during the interviews, although five made comments describing their practices. This study was focused on personal qualities, attitudes, and behaviors of clinicians that they believed might influence clients' attendance at therapy appointments.

To understand these clinics more fully, we need to place them within the larger social and political context. The reimbursement practices of both clinics were similar. Funding came from sources such as Medicare and Medical Assistance. One of the clinics saw a small volume of clients who paid for services through private insurances. The financial requirements and volume of services required to operate these clinics determined the productivity requirements of the clinicians. Approximately 100 kept appointments per month

per clinician was the standard expectation of clinicians at each clinic. Paperwork, staffing, and administrative requirements were determined, in large part, by the funding organizations. Management expectations and feedback to clinicians about their performance were influenced by the financial needs of each organization.

Introduction to the Results

Participants had a great deal to say about missed appointments and clinician influence on kept appointments. Additionally, participants expressed curiosity and had their own questions about the problem.

Many factors, both internal and external, influence clinician attitudes and ideas about missed appointments. Some internal aspects that affect clinician behavior involve personal experiences and personality, include: likes and dislikes, characteristics and attitudes, beliefs, physical health, ability to self-reflect.

External factors include (a) personal living environments, (b) stressors, and (c) the environment of the clinic. This latter aspect includes feedback from managers and supervisors. Emotional reactions and attitudes can influence interactions with patients and, subsequently, the nature of the therapy experience and the likelihood that patients will return

Some participants engaged in self-reflection and attempted to understand the dynamics of sessions to help explain why clients missed. Other attributed external factors such as the weather or time of year. Some understood that practical realities play a role in clients' attendance at sessions.

Several participants welcomed this work. One said, “I think it’s really interesting. I’m glad to be doing this interview to see how I think. Our attitudes and the culture of the agency is a big thing.” When I asked, “What kinds of things can help to reduce missed appointments,” another participant stated, “I don’t know and I think that’s a big part of why I’m participating in this study, to try to help us figure that out.”

As a clinician working in a similar setting as my participants, I suspect that my interest and involvement with those I interviewed affected their responses to me. Some responded to comments I made, or questions I asked, by saying they had never “thought about that,” but that they would try “that” in the future. Together, as we focused on the missed-appointment phenomenon, we created a reality that attempted to describe the clinicians’ impact on the missed-appointment rate in these clinics.

Perhaps I may have had an influence on the clinicians and their future work with their clients. During one interview, I observed a noticeable shift in the attitude of one therapist whose initial comments were negative toward clients she served at a prior job. As the interview proceeded, she displayed more understanding and compassion toward clients who miss appointments. Perhaps the interview process itself played a role in her change of heart, as she more carefully reflected on her experience and understanding of the problem. My purpose has been to study (a) the clinician as a person, how (b) the clinician relates to clients, and (c) how the clinician deals with noncompliance.

I am interested in looking at “evidence-based” clinical relationships. The specific theoretical orientation and its effect on clients’ attendance could be the topic of another study. The findings described below capture the major thoughts and processes involved in

participant understanding and assessment of the missed-appointment issue.

By painstakingly fracturing the data into small bits of information, comparing different data, combining common ideas, and developing categories that included similar ideas, the researcher lifted categories to higher levels of conceptualization, including:

1. Laying the Foundation
2. Responding to the Miss: Making Meaning
3. Responding to the Miss: Reacting to the Miss
4. Responding to the Miss: Therapists' Behaviors
5. Impacting Clinicians' Functioning: Effect of the Work Environment
6. Other Factors Impacting Clinicians: Likes, Dislikes, and Job Satisfaction

Laying the Foundation

Establishing rapport.

All respondents acknowledged the importance of building a positive therapeutic relationship during initial sessions. Therapists trained in a specific modality might be tempted to proceed via the method or technique uppermost in their mind as they begin work with a client. This could be at the possible expense of a solid foundation for the therapy. One clinician said, "If you can develop really strong rapport, that's very helpful in getting clients to come in and want to come in." The same therapist said, "I know some people who said, 'Well, I'm not really interested in therapy.' And through them feeling more comfortable with it, they did come in regularly and they did come in very often."

This therapist was speaking about clients who are forced to come to therapy, whether by probation or another means. Rapport with these client was instrumental in kept sessions. One respondent said, “I think it does impact whether a client comes in, if you really don’t have that therapeutic bond established with them . . . and an open demeanor.” This therapist asks clients about prior therapy experiences. She quoted her clients as saying they used to miss appointments “. . . ‘because I did not feel that therapist understood me or because I felt they were judging me or labeling me.’” This same therapist said, “I have had clients who said, ‘If I did not like you, I would not come in.’” When I asked another clinician if she could influence the missed appointments of clients by her attitude and behavior, she said:

> I think so. I think a lot of it has to do with the relationship that you build with the client and if they feel comfortable and if they feel welcomed, and if they’re ready to do the therapy. So, I think that has influence over whether they come a lot of the time.

One participant said that if clients do not feel comfortable with the therapist, “They have trouble telling the therapist that they’re not comfortable, so I think a lot of people just don’t show up and don’t talk about it.” Another respondent said, “A good therapeutic relationship helps keep clients coming.”

Respondents described how they engaged clients in the first meeting. One said, “I try to find something that I can connect with them on, even if they come in and they have a cup of coffee that day, (I ask) ‘What’s your favorite kind of coffee?’” A new client can begin to feel comfortable in the therapy setting when the clinician begins the relationship with an effort to get to know the other person. This effort can also contribute to clients returning for more sessions.

Another clinician described how she engages new clients:

> . . . let them talk about whatever they want. I won't even bring up the major things unless they bring it up, just letting them get comfortable talking to me. Some people are just an open book and they talk about anything, and other people are a little guarded and reserved which I think is normal and natural. But meeting them where they're at, not pressuring them to talk about things they don't want to talk about. If they have a history of sexual abuse, I'm not going to ignore that but I'm also not going to pressure them about something they're not ready to talk about. That could do more damage or they'll stop coming. They'll quit. "Ah, this therapy thing, too scary."

Participants considered adherence to relationship boundaries very important. One clinician did this and client left treatment. However, the client returned later and the clinician believed that maintaining the boundaries of treatment may have had an impact on the client who came back.

One clinician said that "being relatable" and "non-threatening" impacted two clients who expressed discomfort with the clinician's age. The clinician described one conversation about her age with a client, as follows:

> (I said), "That's a thing that's common and I understand where you're coming from. I'm glad that you were open with me about it." She felt comfortable enough to tell me. (She said), "I like you, though," so she just wanted to tell me about it. Another client said that too—"Oh, you know, you're pretty young," but she kept her appointment, too. So, I think it did help that at least I was relatable.

This therapist has a client whose family member shared a similar reluctance to work with a therapist of a different age category. This client has missed appointments, but always tries

to come in, as the therapist explained.

> "Oh, this is the reason why I missed"—health issues or something like that. She still is always interested in coming to therapy. (I told her,) "If you feel more comfortable, if you prefer someone who is older, I have no problem transferring you to someone. The biggest goal is just for you to continue in treatment." I mentioned that to older clients that I have and (they said), "No, that's fine."

Another participant also discussed "being relatable."

> If they feel like you are stern or very clinical about things, clients don't really like it. I have professors who are really stiff and I know if I saw them for an appointment, I would not want them to be my therapist. I would not come to the next session or reschedule.

All participants said that various qualities and behaviors helped to keep clients engaged. These qualities included:

1. Acceptance…
2. Compassion…
3. Empathy…
4. Listening…
5. Positive energy…
6. Humor…
7. Helping clients feel comfortable and safe…
8. Competence…

Participants mentioned additional traits that draw clients to clinicians, including (a) being "warm," (b) expressing concern, and (c) helping clients process events, instead of telling them what to do. One therapist summed up this relaxed, empathic approach by saying, "I

have clients who have really felt engaged. They're coming weekly. If something pops up, I understand, but they always give me a call."

One clinician described empathy this way:

> I try to put myself in the person's place. When I am here with them and concentrating on them, it's a very intense thing because I'm not only listening, I'm assessing. I'm putting myself in that person's place and trying to see things from their viewpoint. From what they're saying, from what their feedback is, they're able to relate to me because of that.

Another clinician stated that understanding clients' feelings is ". . . part of what brings them back."

When asked if any of her personal qualities are instrumental in getting clients to attend sessions, one respondent said she tries to tailor the interaction to the client, ". . . whether it's language, whether it's personality . . . being able to read them quickly. Is this someone who's going to be more comfortable if I make a joke about something?"

Periodically checking with clients on their assessment of the therapy relationship was described as being helpful in keeping clients engaged in treatment. "These are different experiences than they've had in real life," one participant said. (I ask them), 'What's not working for this relationship, how can I do better for you? Maybe I can't do that, but maybe I can get you (another therapist).'"

One study participant, when asked if she had qualities or characteristics that could cause clients to miss appointments, said, "I can have times where I have trouble figuring out how to phrase things so I'm not the most professional in phrasing things sometimes which can lead

me to be, kind of blunt with my clients sometimes. And some clients don't like that too much."

Educating clients about therapy.

New clients often do not understand therapy, which might be an entirely foreign experience. One respondent shared techniques that help engage clients in treatment, including (a) explaining the attendance policy, (b) explaining the therapeutic process, and (c) asking clients how often they want to attend.

Several respondents described the therapy relationship as a "partnership." One participant felt that explaining the therapeutic relationship as a partnership empowered clients and helped them engage in treatment. "I think it's a power for the client too," the participant said, adding that the message to clients is, "You have the resources within yourself and also the expectation that you can do this on your own.'"

Respondents reported that the educative process at the start of treatment includes communicating expectations for the client. Clinicians explained to clients that therapy as a special time reserved for clients, and communicated the importance of keeping appointments and canceling in advance when necessary.

Non-verbal behavior and countertransference.

The researcher asked participants how their nonverbal behavior like (a) being tired, (b) worrying about personal problems, or (c) being rattled by a previous session—might affect

clients. Participants felt that they communicated an annoyance with clients who frequently complain but do not focus on "working." One clinician tried to reassign such clients to other therapists. Respondents said they try to conceal preoccupation or distress. In fact, one participant voiced her skill at "compartmentalizing" her feelings. Some therapists said they comment directly about feeling tired or frazzled from dealing with another client. One therapist made a point to explain any non-verbal behavior that the client might consider unusual because ". . . some of our clients think it's about them." This therapist talked about a situation where a client misinterpreted non-verbal cues as a sign that the therapist was unhappy with the client.

> She was just reading too much into something. But that did make me more aware of body language, how long sessions are, and making people talk for too long if they want to go. I definitely think we can have an impact, especially in clients who are very intuitive. They watch a lot and if they see you give a look, or if you are not paying attention, or you look at the clock or something like that . . . they can notice those things. We're human. We all sometimes get up too early in the morning or we stay up really late.

Not liking a client can possibly affect the relationship. One therapist stated that it is impossible to like all clients. She feels her dislike might be conveyed via nonverbal behavior. On the other hand, a therapist might like a client too much. Countertransference in all its forms is an important source of information about the therapy. It enters the client-therapist dialogue whether one realizes it or not.

> I want to work, obviously, as professionally as I can. Sometimes (I have) to check myself: "What's really getting under my skin and why do I want to see them?" Maybe there's some countertransference there, something that they're irritating or arising in myself.

One clinician said: "If I take a harsh attitude, I think that's going to motivate them to want to quit . . ." Another participant, who felt that sharing values and beliefs with clients strengthened the connection, said, "When they're talking about their morals or whatever and I have the same beliefs, I can relate more. Maybe it's evident to them that I have the same values.

Responding to the Miss: Making Meaning

Introduction.

The clinician is instrumental in engaging clients in treatment in many ways, such as (a) helping clients remain in treatment, (b) helping clients acknowledge they are not ready for treatment, and (c) helping clients reach their therapeutic goals.

Many internal and external forces influence attitudes and cognitions about missed appointments. How a clinician thinks about the missed appointment can affect internal reactions, which can potentially affect responses to a client. Other factors affect the therapeutic experience, including factors beyond the control of clinician and client. The sections that follow capture the meanings I found clinicians to embrace in understanding the phenomenon of the missed appointment.

Stereotyping.

One participant stated that some clients miss appointments because they lack life skills in following rules. Another participant attributed misses to the "mindset" of people with

mental-health problems. Some clinicians used the term “this population” when describing their clientele. These views can prompt clinicians to take a dismissive view of clients.

Stereotypes can prevent the therapist from understanding, engaging, and keeping clients in treatment—thereby interfering with the development of a positive therapeutic alliance. One participant said, “Clients have a sense of entitlement and feel their actions don’t affect others.” Other participants shared similar perspectives, that clients face no consequences for missing appointments and no have no sense of accountability. Others felt that not paying for treatment contributed to a lack of motivation for therapy.

> I do think that sometimes when you don’t pay for things you don’t value them and there becomes a sense of entitlement. “Well, I can just go when I want to go”—not understanding how it’s disruptive to the business, disruptive to the therapist, inconvenient, just kind of that tunnel-vision thing.

Another therapist voiced similar views, saying, “There’s no financial consequence if they don’t just show up for their appointment. They’re not paying anything for the service, so I think a lot of times they don’t value it. There’s nothing coming out-of-pocket for Medicaid clients.” However, one clinician did not feel that non-paying clients missed more appointments than paying clients.

Several clinicians indicated that they questioned the excuses that some clients gave for misses. “Sometimes you get excuses, wacky excuses, all kinds of excuses,” as one participant said. Another therapist described clients who missed like this:

> For the most part, I feel that it’s their problem. It’s kind of inherent in the business. If you have someone with mental-health issues or drug-abuse issues . . . it’s almost part and

parcel of the problem. They have difficulty taking responsibility. They tend to be impulsive, don't feel like getting up (and) making the appointment.

Another study respondent attributed no-shows to culture, saying, "I think sometimes there can be a culture and maybe it's just in this community . . . it seems to be a little different in some other communities. Their sense of entitlement, 'I can do whatever I want and my actions don't influence others.'" This therapist was unable to explain what she meant about "this community." When she was asked to think about this more, she said the difference between her current clinic, which services "this community," and other places she has worked includes transportation difficulties and agency policy. She said that in her current agency, there is no strict missed-appointment policy and cases can be kept open even if clients frequently miss. One clinician said that her client failed to keep appointments because the client had difficulty (a) saying "no" to the demands of others, (b) letting others' needs get in the way, and (c) not making therapy a priority.

Being motivated / Readiness for therapy.

Clients who are not motivated for therapy miss appointments. Clients are unlikely to keep appointments if someone else suggested therapy and clients don't think they have a problem. On the other hand, as one therapist said, "If the client was willing to change, they would still come to appointments. I had clients who came to their appointments every time, who were from the same population, so it just really depended on them."

The theme of readiness for therapy was mentioned as a factor in missing appointments.

Some of them, when they start missing, are not ready for the therapy. I think they're

probably to the point where they don't want to feel bad. They're lonely or whatever it is that they're feeling, but they're not ready to dive into those feelings and really do work to move past it. It can be hard to sit here and talk about yourself for 45 minutes. I think people really don't know what to expect. A lot of my clients are new to the mental-health center and are just getting started with therapy.

Along with readiness for therapy, another idea that emerged during the interviews was the notion that clients don't understand what therapy entails. One clinician said that some clients are "passive" during therapy and don't understand that the process is collaborative. This contrasts with doctor visits, for example, where the doctor tells you what is wrong and recommends a treatment.

Respondents reported more missed appointments for the first and second appointments after intake, as opposed to the rate for ongoing clients. One clinician speculated that perhaps some clients get what they wanted at the first appointment. Of course, it is also possible that clients do not get what they want when first starting therapy. Perhaps some clients did not yet feel connected enough to the clinician to persevere for a few more sessions.

Acknowledging realistic factors.

Respondents also attributed missed appointments to concrete problems, including:

1. Finances…
2. Transportation issues…
3. Physical illness…
4. Severe mental illness (schizophrenia)…

5. Cognitive limitations…
6. Domestic violence…
7. Homelessness…

One participant said, “We really do see a lot of those things working with lower socioeconomic status. I try to understand their world and their situation and know that that is a part of the territory.” As to how socioeconomic status affects clinic attendance, this clinician said:

> I think they are trying to get their daily needs met the best they can and use the resources that are available. Although mental health is a priority in their life, it is a lower priority than putting food on the table or putting gas in their car. If they need to provide those things for themselves and their family, that should come first. So, I want those things to come before mental health. At the same time, if they’re neglecting their mental health, it’s going to negatively impact those other areas of their life

Seeking to understand the miss.

Some participants had clients who stopped treatment without explanation. This behavior puzzled the clinicians. Without having a conversation with the client, clinicians can only speculate what had happened. Was the person dissatisfied with the therapy? Were they finished? Were they incarcerated? Did they relapse on drugs or alcohol? Did they get ill? Did they die?

Some participants expressed a desire to understand how the miss might reflect events in therapy, and how it might pertain to the client / clinician relationship. Others tended to focus on more external factors as reasons for the misses, such as activity in the lives of the clients. One clinician welcomed the miss as an "opportunity" to explore the potential meanings with the client, sometimes with considerable success. "Sometimes you get them to go places and get insight into things they never realized and are actually able to relate it to them."

Clinicians can use the miss to positively impact therapy. One therapist said:

> It depends on the client. If they're a new client and they miss, I will take it that they weren't ready for therapy. Or sometimes I'll take it they just did not like me and they didn't want to come back and see me. Maybe there is something I did during the session that didn't work for them."

Not knowing the reasons for misses was a primary concern. One participant stated:

> You know, I've mentioned a couple of factors that I think play into missed appointments. But I'm interested, do other therapists experience those same things? Do other therapist experience different things? What do we do to change the no-shows that we have?

One clinician in the study reported that a client told her at the end of the session, "I've talked a lot more about things I didn't want to talk about." According to the clinician, this client ". . . went really deep really quickly, and then he never came back." Another clinician said that she will try to process client's feelings at the end of session that may have been very intense, to prevent the client from not returning for the next session.

One clinician attributed missed appointments for some clients as a type of acting out. "I think (missed appointments are) different even than last-minute cancellations. When they just

no-call, no-show, sometimes I think that it's a punishment in a way, like, 'Well, I'm just not gonna call you'—especially when there's personality disorders."

Another therapist worked with a woman who was complaining about her life. The therapist decided that the client's goals for therapy did not focus on her problem, and proposed a new goal for this client. The therapist explained the results, saying, "I think she missed the next appointment. So, I was then thinking, 'Was that too much for her?'" Perhaps the client missed because it was not *her* goal, but the therapist's. This therapist said she asks herself when clients miss if there is something that needs to change.

A young female therapist attributed missed appointments to the young men who had been assigned to her. She said, "I've had a lot of young guys and they come in only once and don't show up any more." This therapist felt that young men seeing a therapist close to their own ages distracted them and prompted them to not return. The therapist discussed this with her supervisor and asked that she not be assigned such clients.

A therapist working with a challenging client understood the client's misses as an effort to sabotage treatment.

> A lot of my clients have intense trauma and they are women and they come for therapy. They find so many different ways to self-sabotage in their regular daily life and we talk about it here. I'll talk to them about, "I notice you haven't come the past two sessions and you're the one who told me you wanted to come once every week, or twice every week. Are we now starting to sabotage our therapeutic relationship just as we do in the real world?"
>
> Some of them will take it well. Some of them will choose not to come again for a while and maybe call me a month later and say, "Hey, can I reschedule?" With my

> borderline clients, sometimes I'll take the ride with them when they don't show after they've done some intense work, and they need their own time to come in.

Several therapists said clients cannot directly express how they feel about therapists. "A lot of people have trouble if they aren't comfortable with therapy. They have trouble telling the therapist that they aren't comfortable. (They) just don't show up and don't talk about it." One therapist described being ready to discharge a client who kept cancelling appointments. The client called the therapist's supervisor and said she wanted another therapist because her current one reminded her of her mother. However, she was unable to talk to the therapist directly, which explained her cancellations.

Regardless of how much the therapist may try to help the client feel comfortable, there remains an inherent power differential in the relationship. One participant saw another therapist's client when that therapist was out of the clinic. The client told the participant that he missed appointments because he didn't feel that he was getting anywhere with his current therapist, but he was afraid to discuss the topic.

Some clinicians reflected on the content and process of prior sessions when clients missed appointments.

> Maybe you went too deep last time. Maybe you are a transference figure. I think if you're representing their mother and they have a lot of issues and feelings towards their mom . . . I try to figure out, "Was it just you forgot—everyone forgets—or is it really something else going on that we need to talk about?"

Some clients have trouble telling their therapists they no longer wish to come to treatment. As one participant said, "They're really done but don't want to let you down and say, 'I want to stop.'" These clients may feel a certain loyalty to the therapist. Comparing therapy

relationships to romantic relationships, one therapist said, “Break-ups are hard.”

After thinking further about her relationship with a client, a participant acknowledged that her nonverbal manner could have impacted the client’s opinion of her. She decided that clients notice a lot of things about therapists that are not expressed verbally. Another clinician said that clients are very intuitive and notice if the therapist is (a) not paying attention, (b) tired, or (c) experiencing some sort of discomfort. The therapist said that clinicians need to recognize their own limitations and need for comfort, such as dimming the lights or otherwise adjusting the environment of the room. If the clinician is not comfortable, clients can sense that and feel the therapist is not being genuine.

One therapist who had recently become a mother noticed that her missed appointment numbers were higher after giving birth. She reflected on this, wondering if her approach to clients might be different. Was she less nurturing since she now had a 24-hour-a day responsibility for a baby? She didn’t feel she was less nurturing, but said, “I don’t know how I’m perceived on the other end by my clients. They could see or sense a difference.” She had not asked her clients about this but acknowledged that it might be good to do so. She wondered if she had started holding her clients more accountable.

> I think before I might have been more client-centered, of really focusing on their feelings and validating, and supporting. Whereas now I might be more cognitive-behavioral and really drawing connections between their thought patterns and their actions, and confronting and challenging them on those patterns. Maybe I didn’t use as much of that before, maybe being more action-focused now. That’s my agenda and not theirs.

I asked this participant why she might be different in her approach to clients. She said, “I

have little control over my home life with a colicky baby. Maybe I feel that this is somewhere where I'm supposed to make a difference, so maybe wanting to see more fruits of my labor here. I think it would be on a subconscious level. I don't want it to negatively affect my clients and my work here."

Sharing responsibility / Both play a role in the misses.

Several respondents understood that missed appointments involved shared responsibility. Responses on this topic illustrated the relational aspect of treatment and the dynamics (transference, countertransference) between the dyad. One therapist said:

> I don't think that it's always the clinician or it's always the client. It's probably a mixture of both. If it's not working, if the client doesn't feel comfortable, that certainly can be a reason why they're failing appointments. That doesn't necessarily mean it's the clinician. Not to say that we don't make mistakes (or) that we don't have to do some repairing. You have to work together. If I'm doing too much work and they're not doing enough, they're only going to stay as long as I do all the work.

Recognizing the necessary joint effort, another respondent said, "I'll say, 'I'll call you before I leave for the day.' But I don't do that all the time. I think it's some of the client's responsibility to remember their appointment." Yet, the clinician's call can be perceived as caring. Another participant said, "I think mostly it's on the client and their issue, but if I didn't call them to follow up, they may think, 'Oh, she didn't really notice that I wasn't really there.'"

All respondents indicated that their attitudes and behaviors can affect kept appointments.

However, most felt that clients have a part in keeping appointments. Clients might miss appointments for many reasons, including:

1. They are not ready for treatment…
2. They are unable to convey their wishes and desires to the therapists…
3. They do not understand what therapy entails…
4. They have realistic life issues, such as lack of financial resources or transportation, which affect their attendance…

For their part, clinicians are affected by many practical influences, including (a) their working environment with the client, (b) relationships with supervisors and managers, and (c) political pressures affecting the organization itself. These factors are discussed later in this paper.

Finding Other Explanations

Multiple participants, puzzled by no-shows, formulated some theories of their own about missed appointments. One participant said:

> I think people have things come up. The holidays are horrible. The wintertime in general is not ideal. When I do group on Tuesdays, it's generally very low compared to any other day of the week, which is odd. Extremely hot days are really bad, and Mondays recently.

Responding to the Miss: Therapists' Feelings

Participants described various feelings related to missed appointments. Many said they

were felt frustrated, resentful, or irritated. One participant said:

> If they come back the next session, it's, "I'm sorry I was sick. I'm sorry I missed. I'm sorry I missed several appointments." All this stuff has been going on in their life and they're like, "Oh, I don't know, it's been so hectic." And it's like, "Okay, so what's been going on?" And they'll give you non-answers, and it can be really frustrating.

Participants verbalized various emotional reactions to missed appointments, including:

1. Confusion…
2. "Shock" when a client working hard in therapy missed…
3. Disappointment…
4. Sadness…
5. Feeling "kind of lost"…

Two respondents said that earlier in their careers they tended to interpret a miss as their own personal shortcoming. However, this is no longer the case. "I kind of eventually came to realize a lot of their stuff isn't me," one respondent said. "I'm not responsible for them having no money, or their phone being turned off, or them being homeless. Some stuff you can't fix." Other clinicians worried when a client missed. "My established clients, generally I'm more concerned what's happening," a participant said. "Why aren't they coming in?

Participants were sometimes relieved when clients miss. The miss allows extra time to do paperwork. Others said misses made them felt incompetent or even helpless. One participant felt that clients who missed were wasting her time. Some said they felt irritated. Reactions varied depending on the individual clients and what was going on in their life and in the therapy.

The thoughts and feelings that therapists had when clients missed played a part in how

they subsequently behaved toward clients.

> If they're resistant, then I become a little bit resistant. Something in me just kind of stops. It's very hard for me to be sympathetic or try to get them more engaged in therapy, because their mood or demeanor, missed appointments, influences me. It's like you're hitting a brick wall and you keep hitting it.

Responding to the Miss: Therapists' Actions

Outreach efforts.

Most participants struggled to understand why clients miss appointments. For clients who had difficulty with (a) transportation, (b) finances, or (c) housing, therapists made referrals to case-management resources to help with basic needs. Those kinds of interventions helped clients keep future appointments.

All participants engaged in outreach efforts after missed appointments, encouraging clients to return for sessions, either via telephone or letters. However, how clinicians dealt with specific clients depended on:

1. The meaning clinicians gave to the miss…
2. Their understanding of the patient…
3. Their feelings / reaction about the client's miss…
4. External pressures they felt in their environment…

When a clinician understood a missed appointment in a stereotypical manner, e.g., “They lack a life skill” or “They have a certain mindset,” the clinician might call the client, or wait until the client called. If the therapist regarded the client as unaccountable, the clinician might confront the client with “the rules if they want to stay in treatment,” as one participant said. Clients would be warned that their case would be closed if they did not come to sessions. Some participants did not call patients after a miss, instead waiting for the client to re-establish contact. They did not want to spend time on the phone and they also felt they did not want to “chase after clients.” One therapist said that, for someone who no-showed frequently, she would not call after misses. “I can do something better with my time,” she explained. Those who stereotyped clients tended not to explore the miss with them.

Clinicians at both clinics wanted to understand the reasons for a miss. Clinic B staff focused on how management staff affected morale and the trickle-down effect on their work with clients. Staff at Clinic B felt that local culture and clients’ attitude of entitlement explained some of the reasons for missed appointments.

One participant said, “I address it with them, and ask what happened. I try not to show I was frustrated so much as inquiring, ‘Was there an issue,’ (and) ask them to please call.” Some therapists described the importance of calling clients immediately after a miss, unless there was a pattern of not showing.

A participant said that calling no-show clients during the scheduled appointment time showed care. This clinician said that when she made these calls, clients were more likely to return for the next appointment. She underestimated her impact on the client keeping the next appointment. Part of her interview follows.

Therapist: I started doing this a while back . . . I was noticing, I mean, especially, this

time of year, it was just like, cancel, cancel, cancel, all day long. I was involved in the Washington School of Psychiatry and we had an older supervisor there. She would just like tell us ways to get our clients more engaged and kind of be more pro-active and saying things that would kind of help them understand, "You're not just an extra number, your sessions are important to me as well as to you."

Researcher: So, you really conveyed to them that they are important.

Therapist: And this is their time. It helped a lot, and when I first heard that (suggestion), I thought, "That's not going to work. If they're not planning on coming they're not going to come."

Researcher: Why did you think that wouldn't work when you first heard that?"

Therapist: I guess because it sounded too perfect, maybe, and I just assumed that it wouldn't matter to them if they really were not interested in therapy. What difference would it make if I called them?

One clinician had more missed appointments than her peers. She said, "I have quite a bit of this because I tend to be very lenient and very flexible and very soft …" She kept scheduling clients who missed. She did not talk about how she addressed the misses. However, her responses to clients did not appear to affect their attendance. Her supervisor told her to stop calling and close the cases. I asked another therapist, in dealing with someone who was not motivated for therapy, if she felt she could make a difference in trying to get the client to show for appointments. She said:

Initially, I would always plan out what we would do in session, or try to do out-of-session work. But if they are not coming or they aren't committed, then step back. I did try to meet them at their level. If it's just talking and making them feel comfortable, then that's

what I would do.

If clients did not respond to phone calls, therapists would send letters. The letters would generally ask clients to contact the clinic within a specified time frame if they wanted to continue treatment. The letter would explain that their case would be closed if they did not contact the clinic by a given date. For clients who missed the first appointment after intake and couldn't be reached by phone, one therapist would send a letter with a specific appointment date. If the client didn't show for that, the therapist discharged them.

Participants found it easier to close the case of a new client than one who had been coming for a long time. One clinician described the outreach efforts at her clinic as follows:

> Once we don't see them for a couple of months and they have missed several appointments, we try to put something in the mail, kind of, "Hello, how are you? Haven't seen you, what's going on here?" However, they get that letter and kind of think they're in trouble. Because of this letter, which is a very neutrally worded letter, they call and schedule out of fear that they will no longer be able to see the psychiatrist and get their meds. I'm not sure if they're really scheduling because they need to and they want to, or if it's more out of worry that they could possibly be discharged and not have their medication. I know we've looked at that letter. It changed various times so that it's not misinterpreted, but you still never know how somebody will read that.

I asked this participant if the letter has an impact in getting her clients to return. She said, "I don't know about other people. For me it does."

One Clinic A participant said, "It's like pulling teeth to get them to come in." This clinician described her efforts to engage some clients by discussing agency expectations. She

said, “I know some clients who from the beginning, if you lay down the law and say, ‘This is how it is, ‘they do really well with it.’”

How you address the miss is important.

Most participants described asking about missed appointments in a non-judgmental way that expresses concern. They reacted with understanding, patience, and concern when regular, established clients missed. How clinicians address a missed appointment was felt to be extremely important. One clinician said,

> I don’t want them to feel like they’re coming to Mom, and Mom’s gonna yell. Usually, it’s just, “What happened to you? I missed you. I was worried. What’s going on?” Usually we’ll address it then. Maybe it might be an increase of symptoms, maybe it was a drug relapse, maybe they didn’t feel like coming in for a while. Whatever it is, obviously we’ll have a conversation about that, and then I kind of always encourage them again: “You know, we’ve identified these as your treatment needs. For you to meet your goals, it’s really important that you keep your appointments.”

Another study participant reported that her proactive outreach efforts were successful. She said, “If I really have a gut feeling that they’re not going to show up, I’ll call sometimes: ‘Hey, I know we have an appointment tomorrow and I just want to check with you to make sure things are OK. I’ll see you tomorrow at your time.’”

Several participants did not directly address the missed appointment at the next kept session. Whether the subject came up depended on the client. One participant said that some of her clients would feel “chastised” if she discussed the miss with them.

> Some people feel like, "I'm making the choice to come to therapy and if I choose not to come, you don't need to chastise me. I have enough people in the world that are doing that to me." I'll assume they have the power, and we have this conversation and I tell them what's going on, and they don't show the next time, so it's almost a power struggle.

This therapist, however, was very direct with other clients who missed.

> If it's a client that's been consistent every single week for the past four or five months and then all of a sudden they've just fallen off, I'll talk to them and say, "What's going on? Is there something that you're not wanting to talk about? Is there something you're not telling me that's going on in your personal life?"

When asked if she addressed the missed appointment at the next session, another therapist said:

> "Yes, I try to. Do I forget sometimes? Absolutely. But if they're coming back in, I think it's just part of the checking-in process. 'How have you been doing? I know that you missed your last appointment. Can you tell me about that?'"

Many participants sought to understand a miss by evaluating the previous session and questioning their interactions during that session, asking questions like, "Did I go too deep last time," and, "Was that too much for her?" Some participants asked clients for feedback on whether they were satisfied with therapy or wanted to change something about it.

One clinician wondered if misses indicated a desire to end therapy, saying, "I'll make it clear to them, 'If it's something that you don't want to do right now, it's okay if you want to stop. I won't be upset. This is your therapy.'" When I asked this therapist if she thought clients sometimes need permission to stop, she said:

> You can tell them how important it is to you for them to be here, but also at some point

that makes them feel like they need to please you. You've got to be careful the way that you word things so that they don't think, "(My therapist) really needs me." Well, no, you need you.

For clients who tended to miss appointments, clinicians would remind them of the attendance policy and propose closing their cases. Some participants said that administration, in reviewing attendance records, would pressure clinicians to close case. Some therapists kept giving the client the same message: "You need to make appointments, and I care about you."

However, participants would not set firm consequences. One clinician addressed missed appointments with one client by saying, "You know, we've identified these as your treatment needs. For you to meet your goals, it's really important that you keep your appointments." Did this approach inspire clients to make future appointments? "For some of them it will," the participant said. "But sometimes it will help for a couple of weeks and then they'll drop off again."

Another clinician dealt with a frequently absent client by not trying to squeeze her in when she called to reschedule. Some therapists were very direct in confronting clients who missed, stating clear consequences, e.g., that their case would be closed after one more miss. One therapist told a client, "I'm going to have to discharge you for non-compliance because if you're not coming, I can't help you." It was not clear if this prompted the client to return.

Flexibility with enforcing attendance policy was stressed at Clinic A. Therapists there reported that closing a case after misses was done on a case-by-case basis. Supervisors were sometimes consulted and a joint decision was made, in the best interests of the client.

Modifying the treatment.

One participant described modifying treatment if misses became an issue:

> I have said, "We can slow down. We can stay very concrete. We can do worksheets. We can talk about your day-to-day life. This is your therapy. We go where you want to go. We can make a code word if you feel like it's getting too intense. Just say it and we're off looking at butterflies, or whatever we want to think of.

Several therapists offered clients specific days and times to increase kept appointments. This proved helpful. As one therapist said, "I find that (if I tell clients), 'You are scheduled every Friday at 8 AM,' they will be here every Friday at 8 AM or calling me to let me know." One clinician offered this arrangement to a client with memory problems, and another respondent explained that a training session advocated fixed schedules.

> We looked at a lot of psychodynamic theory and the safety that is created by providing boundaries . . . seeing somebody at 8:00 for their 8:00 appointment, not 7:50, if they're here early. Their appointment is at 8:00, 8:00 to 8:50, Tuesday mornings. Do it consistently. I think a lot of the current staff did that, but it's very difficult to provide that (consistent) time slot.

Many participants tried to discuss misses with clients to get feedback on helpful and unhelpful therapy elements. These discussions addressed whether clients feel comfortable and whether they would like new therapists (in which case, a new therapist was offered). Clients tended to avoid dealing with this latter question.

Some participants felt that client reasons for missing appointments were not legitimate. These therapists felt "stuck" in their choice of options for continued therapy. Besides discharging the client, they could choose to not directly address misses, in which case clients

would continue to miss and the therapists would continue to "chase" after them.

The therapist who said she matched clients' "resistance" changed her treatment approach. With supervision and time, the therapist dealt with her feelings.

> Every day I practice helps, and not blaming myself helps. I think, just taking it for what it is. OK, so they miss so many appointments, but they are here now, so what can we do to work with whatever is stressing them out, or whatever symptoms they're presenting right now? Let's just focus on that. Hopefully if we can focus on that and they see that I am receptive even though maybe they've missed, then they may be willing to come back to the next session.

One clinician said that in her growth as a clinician, she learned to allow clients to express their feelings toward her.

> I found when clients would talk about any feelings about me or comment about me or personal things about me, I immediately found myself a little bit recoiling and firmly addressing it, like "We have boundaries." As I developed as a clinician, I am able to say, "Tell me about those feelings. Let's talk about that," and really not be afraid. That's really helped me (and) my kept rate.

Many participants welcomed the research study and hoped results would help them deal with missed appointments in the future. As one therapist said, "We need to do more with following up. 'Are you done? Have you decided to quit?'" In terms of finding new ways to address misses, one respondent said, "Having a different approach to a longstanding problem oftentimes helps bring the person back."

Clinicians' Functioning: Effect of Work Environment

Feeling unsupported by management.

In both Clinic A and Clinic B, the behavior and attitudes of management impacted clinician morale. It is difficult to be energetic and attentive to a client when one's morale is suffering. One therapist talked about the pressures that clinicians felt when management emphasizes the number of misses and cancellations, and thus "productivity." This emphasis can, the therapist said, discourage practitioners, who might equate falling short of productivity goals with being bad at their jobs. This therapist said that when she first started at the clinic, she was overbearing at times, calling clients repeatedly in an effort to meet productivity goals—all while feeling pressure from management. However, she later stopped obsessing about the numbers and was not as driven in her outreach.

Another clinician at the same clinic reported that she felt clinicians were "blamed" for misses, even when a client had realistic problems preventing attendance. One therapist spoke of the impact of management's negativity, saying, "Sometimes the atmosphere of the clinic affects the therapists' performance. If there's too much micro-managing . . . things are said to you with a certain condescending or threatening attitude. That can affect how a clinician (performs)." This kind of environment can make it difficult to focus on the client, and a negative work environment increases stress levels. Therapists in Clinic B attributed low morale and burnout to negativity from management, who focused on productivity and numbers. "Sometimes you feel more of a factory worker," a participant said, "bringing clients in and out, rather than the focus being on the clients themselves or the employees."

Participants commented that their input and ideas were not welcomed at staff meetings. One therapist stopped talking at these meetings because therapists were often "shot down"

when trying to make suggestions. At this clinic, a new program aimed at reducing the missed-appointment rate was not working. Staff did not fully understand the program. It was developed by management, without input from clients and clinicians. Therapists felt drained and exhausted and said their morale affected their work with clients. They felt management did not value them or their clients. As one participant said, “It’s all about how many visits you can get. It’s all about numbers.”

Therapists at both clinics heard mixed messages about closing or keeping cases open. They considered the expectations of the state and agency as inconsistent. Therapists wondered if their confusion might be conveyed to clients. At one point, staff were told, “Get the dead weight off your caseload.” Later, they were ordered not to close cases too soon. One staff member reported that she was told to tell no-show clients “. . . that it takes away from someone else who’s willing to get the treatment.” This clinician refused to pass on the message.

Participants expressed additional points relating to the work environment, including:

1. New productivity mandates, in light of pre-existing bureaucratic responsibilities like excessive paperwork…
2. A lack of appreciation. As one participant said, “I think when you don’t feel appreciated, you get frustrated, burned out, and tired. You don’t have as much to give”…
3. Management pressure can cause therapists to be harsh with clients, and therapist feelings can affect whether a client returns…

4. Implications from management that one can't be a good clinician if clients miss appointments. For one participant, this implication prompted her to (a) feel scared, (b) take the criticism personally, and (c) develop a lack of confidence.

The following interview exchange illustrates the importance of how management addresses missed appointments with staff.

Researcher: You said in the beginning that if you are harsh with clients, they'll probably miss more appointments. I wonder with the staff, if there's a harshness or negativity that is producing the very thing you don't want.

Participant: Exactly.

Researcher: Has anybody talked to you about the missed appointment rate in a positive way? "What can we do? What thoughts do you have?"

Therapist: No, it was just mentioned to me in terms of productivity.

Researcher: If it were brought up as a topic for discussion or sharing, would that be helpful?

Therapist: Yeah, I suppose. Let's put it this way, I don't mind correction but I don't like criticism. Sometimes I've had to take criticism and focus on, "What do I need to change?" I still remember the way it was told to me. If it was told to me in a condescending way, if it was told to me in a harsh way, (like,) "If you don't do this then you can just go someplace else."

Participants mentioned that mandatory paperwork interferes with kept appointments. One participant recounted a former client saying, "I'm going to someplace else. I'm not coming back. First of all, I have to come in and for the first two sessions I have to fill out all this paperwork and now the appointment is wrong. I'm going somewhere else. I need somebody

to talk to."

Another clinician said high caseloads affect her ability to address missed appointments. She said, "Sometimes my caseload is so high and I feel so overwhelmed, emotionally stressed, and I may not put 100% into following up with my clients or exploring with them their kept rate."

Feeling supported by management.

"The administration here has really been great as far as supporting clinicians as well as making sure we meet the budget needs for the company as a whole," stated one respondent. At that respondent's clinic, several clinicians indicated they felt supported by management when supervisors reviewed caseloads with them and identified specific cases to close. Another clinician said she was able to set stricter limits on clients who frequently missed, given management's direction to close cases. Having the administrative staff make reminder calls to clients a day before appointments helped therapists. Most of the staff at Clinic A reported positive change taking place on the part of the management's attitude toward them.

For one clinician at Clinic B, responding to management pressure helped her address misses more directly with some clients. Another participant received feedback that, instead of being high-pressure, was constructive and positive.

> For a long time there was none of that, recognition. "No you didn't make your goal, but you improved over last month." Lately there's been some of that. That's a positive step. One month, I saw 64 people and then the next month I saw 75. The e-mail I got said, "Hey, that was a good improvement. Good job."

Staff at Clinic A felt much more support from management than staff at Clinic B. One person

at Clinic B said management had started giving her some positive feedback.

Another participant described a change in her approach with clients that she believes increased return appointments. Her clinic provided training from an outside organization, a clear indication of management support for clinicians. For the participant, who felt insecure about herself and her abilities, the training boosted self-confidence and helped her become more open and accepting of clients' transferences. She believed that this positive change helped her develop as a person, and it improved her rate of kept appointments.

One therapist assisted clients with transportation and other case-management issues, saying. This therapist said of a client, "It was only when I got her to come into (a case-management program that provided transportation)—and it took me months to get her into doing that—that she started coming in more regularly. Had she not done that, I don't know if she would have come in more regularly."

Other Factors Impacting Clinicians: Likes, Dislikes, and Job Satisfaction

The researcher asked participants about their preferences working with certain types of clients, including client ages and diagnoses. Most clinicians had caseloads to their liking, and expressed a genuine interest in doing therapy and excitement from seeing clients make progress. One participant said. "I very much enjoy providing counseling. For me, it's more than just a job. It's kind or what I consider a life calling—to try to reach out and help other people." Another respondent said she liked the wide variety of presenting problems in clients.

Others reported disliking the volume of paperwork required by management. One said she disliked, ". . . reluctance to change on the part of the client when I'm trying to move them to

a point of progress and perhaps they're not ready or it's just not the right timing in their life." Another said that the work can be "…mentally exhausting, to focus that long with other people, eight hours a day or more."

Compassion fatigue was a consequence of working with clients who had experienced severe trauma. One therapist reported that many of her clients had been sexually abused. With these clients, it was especially important that the therapist remain present in the room. As one therapist described, "I didn't hear the last three sentences that this person said. So, then you're trying to play catch-up and you're trying to bring yourself to the present, hoping that the person didn't realize your brain was somewhere else."

Another therapist reported emergency-petitioning a client and the next day another client reported hitting a bicyclist while driving to the appointment. The accident resulted in the death of the victim. The therapist said, "I ended up feeling numb most of that week."

Chapter V

Discussion and Conclusions

Interpretation of the Results: Part I

This dissertation has focused on how clinicians view their impact on missed appointments in outpatient psychiatric clinics. Specifically, it focused on the importance of establishing and maintaining connection with clients in psychotherapy. This idea might seem self-evident, but basic notions can prove complex.

All participants considered missed appointments a major concern and wanted to understand why clients miss. Most research cited earlier in this paper emphasizes the nature of the therapeutic relationship in keeping clients in treatment. Some studies report efforts to decrease the no-show rate by implementing structural changes in organizations. These changes sometimes involve increased client contact before and / or after a miss, thereby targeting the therapist-client connection.

Working to understand the meaning behind a missed appointment can affect future kept rates. Casement said, “When patients feel they are not being understood, it is not always easy for them to communicate this to someone whose professional claim is to know about these things” (Casement, 1985, p. 17). Behaviors, such as missing sessions, may be the only way a client can communicate dissatisfaction with the therapist. Casement also pointed out (1985, p. 3) that therapists unconsciously convey a great deal about themselves: “What is not always acknowledged is that patients also read the unconscious of the therapist, knowingly or

unknowingly." Relational psychoanalysts such as Irwin Hoffman (1983) point to the significance of this.

The concepts of "connection" and "relatedness" need to be addressed to understand missed appointments. Clinician responses to missed appointments are affected by internal and external influences. All humans seek relationships. Client histories often include disturbed relationships that cause difficulties which prompt clients to seek therapy. A warm, attentive, and accepting demeanor is more likely to draw a client into the therapy relationship than a distant, uninterested, or judgmental demeanor. Study participants listed various qualities that they believe help engage the client. Degrees of relatedness and connection could possibly affect clients' attendance at appointments, though this study did not intend to measure that. Some participants reported that factors in their client relationships impacted future attendance. New research could explore this by showing correlations between these factors.

Participants stressed the importance of engaging clients at the beginning of treatment. This process, according to participants, includes the following qualities and attitudes:

1. Acceptance…
2. Concern…
3. Caring…
4. Empathy…
5. Listening carefully…
6. Sensitivity to the client's agenda (not therapist's)…
7. Instilling hope…
8. Educating clients about therapy…

9. Negotiating the details of the treatment…
10. Encouraging client feedback about the therapist and the work…

When therapists labeled or stereotyped no-show clients, e.g., "It's part of their mindset," a barrier went up between client and therapist, precluding an understanding of missed appointments. Barriers interfere with the connection between the two persons in the dyad. Do these attributions (defense mechanisms) serve to disguise the therapists' feelings of failure, disillusionment, incompetence, and guilt? Therapists did outreach and reviewed the attendance policy with clients, but some clients continued to miss. What did the outreach and reviews lack? Was it perhaps the genuine, real connection between client and therapist in which both parties address what is happening in the relationship? Several participants were at a loss when they felt they did everything to engage clients but misses continued.

How therapists made meaning of missed appointments potentially affected their feelings and responses to clients. Clinicians expressed various feelings after clients missed, including:

1. Frustration
2. Concern for the client
3. Disappointment
4. Relief

Unfiltered reactions can communicate negative messages. Transference and countertransference are components of therapeutic relationships, and were acknowledged by study participants. All respondents said they tried not to conceal negative reactions However, multiple respondents felt that their non-verbal behavior could be conveyed to clients and could affect whether clients returned.

Some sought to reflect on what was happening in the therapeutic relationship. This self-

reflection could potentially open therapeutic dialogue and affect clients' future attendance. However, this study did not measure such a correlation. Multiple participants thought of misses as a response to the therapist's behavior or as an enactment that deserved further exploration. Others described looking beneath the surface and trying to understand unconscious communication in the therapeutic dialogue.

Realistic factors will always affect appointment keep rates, and study participants acknowledged this. Additionally, participants expressed that both client and therapist share responsibility for attendance, and that some clients are not ready for therapy.

This study found that therapists who sought to understand what misses meant and what clients communicated by missing would perform outreach and try to re-engage clients. They did this via several methods, including:

1. Calling clients or rescheduling an appointment…
2. Working on building rapport …
3. Discussing the missed appointment with the client…
4. Seeking client input about how their therapy was going…
5. Critiquing their own behavior with the client…
6. Negotiating a treatment change or modification with the client…

On the other hand, some clinicians who were frustrated or irritated with clients due to misses wanted to close the cases quickly or would inform the client of clinic "rules," stressing the consequences of more misses.

Therapists who understood clients' practical realities offered case-management solutions, such as transportation help or scheduling changes. These clinicians worked to help remove barriers that appeared to impact missed appointments. Others expressed reluctance to address

the missed appointment directly with clients. One participant said she didn't want clients to feel punished, while others avoided "confrontation," or did not want the client to feel criticized. One participant did not know why she did not address it. This failure to focus prevents an understanding of the enactments that hide the real meaning of behavior (McCabe & Priebe, citing Foreman & Marmar, 1985).

One study participant welcomed missed appointments as an "opportunity" to understand more about the client and therapy. Clinicians with more client relatedness and connection reflected on the session or sessions prior to the miss for possible meanings for the behavior. See Figure 1 below, which lists clinician comments and reactions to clients, and rates the degree of connection that might be implied by such responses.

Figure 1: Clinician Degree of Connection with Client (A Continuum)

Distant Connection	Moderate Connection	Strong Connection
"That Population"	"I try to make them feel comfortable."	Therapist is worried when client misses.
"They don't have the courtesy to call."	"I will give them appointment cards or call them the evening before the appointment."	"I follow-up with them and make sure they know I do care."
"That's part of a life skill they're lacking—not following the rules."	"If I take a harsh attitude, that's going to motivate them want to quit.	"If that therapeutic relationship isn't established, they won't come back."
"Management's going to make me close your case."	"Let's get to know each other first."	"Wow, I can't believe they missed, I hope they are okay
"There's some personality stuff going on."	Wondering what the miss is all about.	"I would let the attendance requirement slide because of what was going on with her."
"You are resenting them because they don't really want to change."	"Their wants and needs come first."	"I was sad I didn't get to work with her anymore."
"It's hard for some people to take the initiative to help themselves."	"Good rapport can help someone get engaged."	"I want my clients to feel empowered."
"If they have mental-health or drug-abuse problems… they have difficulty taking responsibility."	A change in clinician's personal life caused her to question how the change may have affected how she dealt with clients.	"I ask them for feedback on how they feel about me and the therapy."
"If they are chronically mentally ill, it's hard to deal with that mindset.	"Maybe it's my agenda and not theirs."	"Having the same values and beliefs can strengthen the connection"
"Clients blame us or the receptionist if they miss."		

"I had a lot of countertransference that made it hard for me not to be judgmental."		
"I don't call after they miss, because they might want a session over the phone."		
"Not wanting client back because she missed."		
"Clients have a sense of entitlement and feel their actions don't affect others.		

The Significance of Connection

The results of this study describe clinician experiences of their impact on missed appointments. All respondents described their qualities, characteristic, attitudes and behaviors that they have displayed in therapeutic relationships. My interpretation of the findings is as follows: How clinicians respond to misses reflects the degree of connection versus emotional distance in the therapist-client relationship.

At this point, we should discuss the basic human need for connection and its origins. Melanie Klein (1946) wrote:

> I have often expressed my view that object relations exist from the beginning of life, the first object being the mother's breast, which to the child becomes split into a good (gratifying) and bad (frustrating) breast; this splitting results in a severance of love and hate. I have further suggested that the relation to the first object implies its introjection and projection, and thus from the beginning object relations are molded by an interaction

between introjection and projection, between internal and external objects and situation. (p. 138)

Klein believed that analysis of transference can prompt changes in the client's relationship with the analyst and others in the client's life. Change occurs via the "relationship" with the analyst (Klein, 1952). Klein emphasized the idea of the centrality of the clinical relationship and primacy of object ties in life. This touches on an important implication of my study, namely, that relationships matter and how clinicians think about clients can affect the treatment process.

Instead of "pleasure seeking" as Freud theorized, Fairbairn believed that "libido is not pleasure-seeking but object-seeking" (Mitchell, 1988, p. 24). Object-relations theorists focus on the infant's early interactions with the mother as critical in the development of the internal world and the unfolding of the psychological self (Fairbairn ,1958). Fairbairn believed that the real, personal relationship of analysts with patients is the critical element in therapy.

In terms of object-relations theory regarding personality, client disabilities represent the effects of unsatisfactory and unsatisfying object relationships experienced in early life and exaggerated within inner reality. If this view is correct, the actual relationship between the patient and the analyst must constitute a therapeutic factor of prime importance. The existence of such a personal relationship in outer reality provides a means of correcting the distorted relationships of inner reality, which influences client reactions to outer objects. It also provides the patient with an opportunity, denied in childhood, to undergo a process of emotional development in the setting of an actual relationship with liable and beneficent parental figure (Fairbairn, 1958, pp. 98-99).

D.W. Winnicott (1956) studied the early infant-mother relationship in developing his theories of development and psychopathology. He spoke about "primary maternal preoccupation, which he described as follows:

> Only if a mother is sensitized in the way I am describing can she feel herself into her infant's place, and so meet the infant's needs. These are at first body needs, and they gradually become ego needs as a psychology emerges out of the imaginative exploration of physical experience (p. 223).

Is this description analogous to the empathic relationship a therapist needs to have with a client? Is this "starting where the client is, listening and being attentive to the person of the client"? Participants interviewed for this research described "empathy" and "starting where the client is" as significant ways to establish connection. Participant responses to no-show clients might speak to the quality of this connection. For decades, psychoanalytic and social-work literature have explored this connection or type of relatedness, as discussed in the "Literature Review" section of this paper.

Anger and frustration at no-show clients can influence how clinicians deal with misses. These feelings can be accepted and processed, leading to different responses than the original emotional reaction. What mother is not frustrated or upset when a baby cries endlessly and she loses sleep in order to calm the infant? Her feelings cannot be denied, but her response to the infant can be a positive one in the end as she incorporates the child's pain and responds in turn with a calm and loving response. Participants in this study acknowledged the importance of recognizing countertransference, and they also understood that nonverbal behavior can impact clients.

William Meyer (2001), discussed the no-show phenomenon from his years of client

experience. He positions missed appointment as a test that clients introduce to discern whether the therapist will respond like important, needed others in the past. Meyer stated, "This is a test that must not be failed" (p. 332). His portrays the dynamic nature of the clinician-client relationship as having behaviors acted out on both parts of the dyad.

> Consequently, many individuals, especially those who are overwhelmed and psychologically unsophisticated, may approach mental health care with great suspicion. One might be frightened that the therapist will find him crazy and send him to a hospital. Another might feel sick at the thought of disclosing the hurt and pain of her childhood memories. Still another panics at the thought of getting close to someone in a caretaking role who would at the very least be unattuned to her needs and would more likely be shaming and guilt-inducing. It is no wonder such patients enter therapy with great ambivalence, and we can see why it is essential for clinicians to be knowledgeable about identifying and working with such potent dynamic considerations. If we grasp the simple profundity of these ideas we will see how glib and superficial are words like 'resistant' and 'unmotivated' to describe our no-show clients (p. 329).

Irwin Hoffman (2002) wrote about the inter-subjective nature of psychoanalytical relational work. The dynamic function of the therapist-client relationship is instrumental in effecting results. Relating is not the only critical component. The patient's interpretation of the analyst's countertransference helps reveal resisted aspects of the transference (2002). While Hoffman does not state that this approach helps clients keep appointments, a piece of research cited earlier in this paper (Muran, et. al., 2005) described how Brief Relational Therapy, a model which combines ideas from relational psychoanalysis and humanistic psychotherapy, resulted in fewer missed appointments for study participants. Is this perhaps

due to the intensity of the relating in Hoffman's model, in which attention to the deeper connectedness back and forth is the process in which the work takes place?

Clinicians interviewed for this dissertation experienced many different reactions to no-show clients. My analysis of the data suggests that the degree of relatedness or connection to clients could affect return rates. The nuances of this connection are complex and need to be studied in more detail, perhaps in future research.

Interpretation of the Results: Part II

Clinicians at both clinics felt pressure from administrators and managers to meet productivity requirements. Some felt demeaned and reported that their morale was affected. They described how poor morale affected their relationships with clients, which could convey disinterest and lack of caring. Some study participants described how they felt supported by management staff. Staff at Clinic B attributed some of the missed appointments to policies and procedures set up by management. They reported being exhausted and not wanting to "go the extra mile" for clients. They seemed beaten down. The larger agency environment felt antagonistic. They did not feel comfortable making suggestions at meetings and stopped trying to give feedback to management. They reported that their clinic had a high staff turnover rate.

At Clinic A, morale was better than at Clinic B, although participants made comments about Clinic A management having been different in the past. The current administration was viewed positively, although one clinician felt harshly criticized about missed appointments. The attendance policy changed at various times, a result of administrative issues and fiscal concerns. At one point, this agency's policy was to close cases after a certain number of

misses in a specific timeframe. However, the policy changed, and clinicians were told not to close cases too quickly. If a client returned too soon, the cost for an initial appointment was higher than an individual session. Initial assessments and diagnostic evaluations were reimbursed at a high rate.

These kinds of policy changes could confuse therapists and clients. They could also preoccupy therapists with concerns about current policy, the number of misses, etc. This could make therapists less likely to explore reasons for misses. Looking at the larger economic and political environment, we see larger forces at work affecting the policies and procedures of community clinics. Reimbursements for services are limited, as are many insurance-dependent medical services. To keep afloat, clinics rely on volume to meet budgetary needs.

If we look at the larger "modern" and "postmodern" cultures, we find that mental-illness treatment focuses on alleviation of symptoms via medication and techniques often aimed at short-term changes. David Howe (1994), a professor in the School of Social Work at the University of East Anglia, Norwich, has written about the influence of modernity and postmodernity on social work. Surface understanding, not depth, takes precedence in today's world. The complexity of the individual is not valued. What we see is loss of the whole "subject," and clients as well as clinicians become "fragmented." Dr. Howe wrote, "Clients are no longer cases but consumers and contractors" (1994, pp. 528-529). Howe also said:

> The social worker's practices are more likely to be task-oriented and performance related, quantifiable and measurable, product-minded and subject to quality controls. Procedure manuals and lists of competencies define more and more what social workers should do and how they must do it. Professional discretion disappears under a growing mountain of

departmentally generated policy and formulae (p. 529).

When clinicians are treated as instruments to generate income instead of professionals treating individuals with mental illness to improve individual lives and society, morale sinks and the client can feel dehumanized.

The Holding Environment

D.W. Winnicott (1960) discussed the holding that the mother provides for her infant, and the related concept of "environmental provision," which he described as ". . . reliable in a way that implies the mother's empathy" (p. 591). He said: "Holding includes especially the physical holding of the infant which is a form of loving" (p. 591). The "holding environment" facilitates "the individual's discovery of the self" (Winnicott, 1969, p. 711).

We can extrapolate a similar type of psychological empathy that is critical in meeting the needs of psychotherapy clients. At least, that is the case if we believe the therapy relationship can be a new relationship that alters earlier internalized, problematic object relationships and dysfunctional early relationships, or deficits in development of the self as Kohut (Siegel, A., 1996) described. At this point, we should consider that in therapy, failures of the therapist can be used constructively by the patient, as Winnicott described (1955-56).

> *The patient makes use of the analyst's failures.* Failures there must be, and indeed there is no attempt to give perfect adaptation; I would say that it is less harmful to make mistakes with these patients (those dealing with a false self) than with neurotic patients. Others may be surprised, as I was, to find that while a gross mistake may do but little harm, a very

> small error in judgment may produce a big effect. The clue is that the analyst's failure is being used and must be treated as a *past* failure, one that the patient can perceive and encompass, and be angry about now. The analyst needs to be able to make use of his failures in terms of their meaning for the patient, and he must if possible account for each failure even if this means a study of his unconscious countertransference (p. 219).

Elsewhere, Winnicott (1982) has stated:

> . . . the mother's main task (next to providing opportunity for illusion) is disillusionment. This is preliminary to the task of weaning, and it also continues as one of tasks of parents and educators. In other words, this matter of *illusion* is one that belongs inherently to human beings and that no individual finally solve for himself or herself, although a *theoretical* understanding of it may provide a *theoretical* solution. If things go well, in this gradual disillusionment process, the stage is set for the frustrations that we gather together under the work weaning . . . (p. 13)

Therefore, the "good-enough" therapist makes mistakes, which can be used to enhance the treatment. The perfect mother and the perfect therapist do not exist. Reality is flawed.

In the therapeutic relationship, the clinician has the task of "holding" the client within the framework of treatment. This provides a safe environment and a context for the work to take place. This is a special place for the client. "Holding" needs to be consistent and predictable. Therapist-related deficits in this environmental container can affect the client, just as deficits in the mother's "holding" of the infant can impact the infant's development. Failure to provide therapeutic consistency, e.g., being inattentive or judgmental, will weaken the holding environment and interfere with the process. Maintaining clear boundaries and seeking to enhance the structure of the therapy—for example, by providing appointments at

the same time and day each week—can strengthen the holding environment. One clinician in my study was sensitive to this need for structure and modified treatment by offering a client a regular day and time for the sessions.

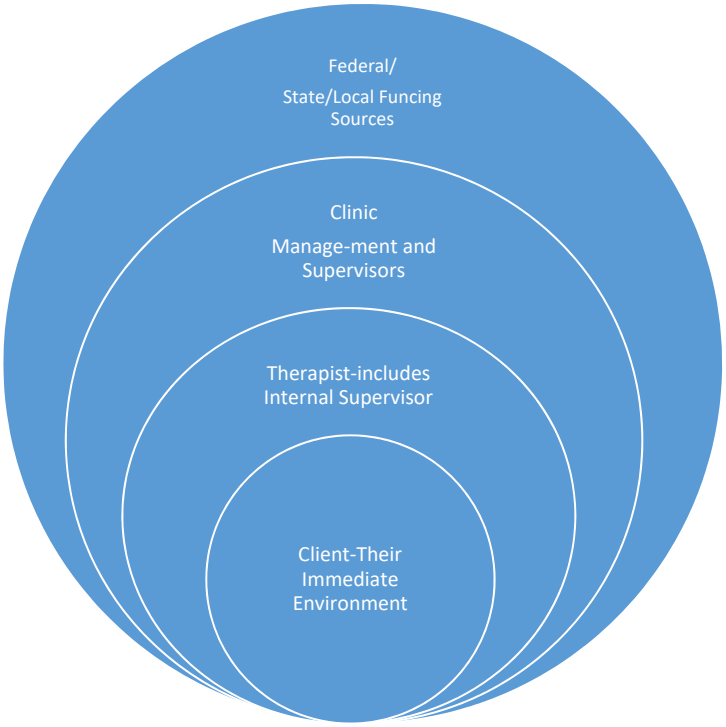
This "holding environment" has many layers. Casement (1985) wrote about the "internal supervisor" as an added help in viewing what happens in the therapeutic situation, a type of internal holding environment. This amounts to an objective third eye on the process as therapy is happening. Self-reflection on the part of study participants can be considered as a type of checking with their "internal supervisors." The external holding environment consists of several components, including (a) supervisors, managers, and administrators, (b) colleagues, and (c) funding sources.

At both clinics in this study, therapists experienced managers and administration as supportive or harsh, or a combination thereof. Some described how their managers and administrators affected morale and thus the ability to treat clients. How one's environment "holds" the clinician can impact the quality of the "holding" that the clinician can provide in the treatment setting. In addition, the larger social and economic environment, which includes insurers, surrounds the work of community clinics and can affect staff morale. Deficits in holding can alter those within the holding environment. Therefore, all the layers of holding can impact the clinician and potentially the quality of the therapeutic work. (See Figure 2 on the next page.)

Study participants described the "holding" of the client by the clinician in terms of the clinician characteristics, qualities, attitudes and behaviors toward clients. Clinicians also described the nature of their own "holding" by the layers surrounding them in their work, specifically the larger agency and those who reimburse for services they provide. A parallel

process takes place between each layer of this larger holding environment. Each dyad can be considered a recapitulation of each layer above. And that is why the environmental landscape is critically important in viewing the impact on missed appointments.

Figure 2: The Holding Environment for the Client / Clinician / Clinic in Outpatient Psychiatric Clinics



What Research Participants Taught Me

Participants in this study believed they impacted client attendance at therapy appointments. They felt that their attitudes, qualities, characteristics, and behaviors affected clients. They described the significance of the therapeutic relationship and gave specific examples of their efforts to engage clients and maintain attendance. They also discussed how their work environments affect them, stressing that a negative environment was demoralizing and could consequently affect their work with clients.

Many participants welcomed this study and wanted to understand why clients miss appointments. Their eagerness to focus on this subject surprised me. Some felt they really did not get the "truth" from clients about reasons for misses, which prompted multiple participants to adopt a self-reflective stance. A few participants seemed to blame clients or management. I learned that clinicians who tried to understand what clients communicated by missing seemed more connected to clients. I learned what therapists thought about a missed appointment appeared to be instrumental in how they dealt with it.

I also learned that all the layers of the "holding environment" in outpatient psychiatric clinics are important components in addressing the missed-appointment problem. The type of supervision and impact of management attitudes and behaviors toward clinicians impacted clinicians' morale and could influence clinicians' interactions with clients.

Another thing I learned was that findings were constructed by the interactions between

participants and myself. Some of my comments prompted participants to self-reflect before and after they answered certain questions. In addition, some participants indicated that they were stimulated to think about strategies to help clients keep appointments.

Limitations of the Present Study

The researcher did not speak to clients themselves about their experience of the therapists' handling of cancellations or no-shows. I was only able to ascertain some clinicians' belief that their actions impacted return rates. I did not interview managers and administrators, who set policies and procedures that influence clinician behavior and work.

Research Implications

I selected constructivist grounded-theory methodology in undertaking this research. This is an interpretive approach. I organized research data into codes and, ultimately, abstract conceptual categories. In constructivist grounded theory, the interview process is co-constructed. Data results from the joint interaction between researcher and participant (Charmaz, 2006). Initial coding illustrates relationships within and between categories, and subsequent coding further develops the categories into higher-level conceptual concepts. The final concepts are connected and form a theory grounded in the data (Creswell, 1998).

Many participants indicated that they influence the missed appointment. Some felt that clients have more responsibility for keeping appointments. Others felt that both the clinician and the client play a role. Most of the clinicians interviewed expressed curiosity about the issue and expressed hope that the study would reveal information that would help them deal

with the problem. In addition, many participants described the importance of management support (or lack thereof). The selection of grounded theory seemed to fit this research.

Future research into the missed appointment phenomenon could focus on the following:

1. Interviewing clients to find out their thoughts and feelings about (a) appointments, (b) why they miss, and (c) what could help them keep appointments.
2. Seeking client thoughts about the therapist relationships, e.g., what clients like and don't like, and any other ideas they have. It is suggested that the research be done in similar settings as this research was conducted—outpatient psychiatric clinics.
3. Comparing clinicians of various theoretical orientations, e.g. psychodynamic, cognitive behavioral, and other models, and finding if missed-appointment rates vary across approaches.
4. Learning how clinicians process the many feelings and reactions they have toward clients who miss.
5. Approaching management staff and asking their thoughts about missed appointments and what they think is happening when clients miss.
6. Recommending that management staff carry a small caseload and, after a period of several months, give their thoughts about why clients miss.
7. Studying therapists matched with supervisors who continually discuss missed-appointment issues in regular supervisory meetings. Measure missed-appointment rates before this supervision begins and after a period of 6-12 months with supervision.

8. Shorten the intake process and make the first appointment an engagement session in which clients talk about what they want from therapy and therapists discuss what therapy is about, including the importance of making a commitment for at least a specific number of sessions. Discover whether this process decreases the no-show rate after initial sessions.

Clinical Implications and Recommendations for the Future

This study approached the missed-appointment phenomenon within the context of "connection" and the "holding environment." With those concepts in mind, the researcher offers the following recommendations:

1. It is essential to view therapeutic work in clinics within the context of the larger "holding environment," as illustrated in Figure 2. The larger economic and political environment of these clinics cannot be easily altered. However, the inner layers of the holding environment (higher administration, management, supervisors) can be engaged in understanding and solving the problem. For example, by providing positive support to clinicians instead of targeting them as "the problem" because their numbers are not "up," management can be of assistance . . .
2. Administrators and managers should receive training about factors affecting "no-shows". . .
3. Clinicians and clients would benefit from a decreased volume of client-intake paperwork, instead focusing on "engaging" new clients by getting to know them.

Often the volume of information initially gathered is time-consuming and can inundate the new client who may feel "lost" in the process. The clinician focuses on the "information" needed to be gathered rather than trying to "connect" with the client. In addition, most studies report that the show rate for those returning after the initial intake appointment is very high. This is time that could be better used for other clients . . .

4. Training programs for staff are essential. In my experience, most current training programs focus on various treatment techniques and methods. There is often an emphasis on the latest "evidence-based" models. While it is important to be educated about various models, an emphasis needs to be on the therapeutic relationship: (a) what it is about, (b) how to initiate it, and (c) how critical it is to keeping clients in treatment and ultimately, helping them make the changes they are requesting. Psychodynamic theory focuses on understanding the deeper meanings underlying behavior. Those who do not have a background in psychodynamic theory may not be able to grasp the intricacies of these models. However, specific concepts can be taught which would help, such as learning about non-verbal and unconscious communication, as well as transference and countertransference. In addition, training clinicians to focus more on the "relationship" in their work with clients is critical . . .
5. Supervision of clinical staff can focus on the factors that affect change while reducing missed appointments; i.e., developing and attending to the relationship through which change occurs . . .

Implications for Social Work Practice

Schools of social work can benefit future clinicians by focusing on the clinical relationship and its place in psychotherapy treatment. Providing training in psychoanalytic psychotherapy is recommended because this theoretical orientation provides an in-depth understanding of psychopathology and the psychotherapeutic relationship.

Summary and Conclusions

This research has described how clinicians experience their impact on the missed-appointment phenomenon. Many participants felt that they clearly conveyed warmth, caring, respect, etc. to clients via verbal and non-verbal behavior. Many therapists said they have grappled with the issue of missed appointments. Most respondents indicated that kept appointments depend on both the client and the clinician. Participants who wanted to deeply explore reasons for missed appointments tended to examine the content and dynamic of therapy interactions. Some were able to re-engage clients by reaching out to maintain connections. The study found that "connection" and "relatedness" on the part of the clinician are critical in the therapeutic dyad. This can sometimes be difficult for clinicians when caseloads are high and numbers are the measurement of "success."

Clinicians in outpatient psychiatric clinics considered the workplace environment to be important. Clinicians are expected to provide a nurturing, safe, and growth-producing environment in the therapeutic dyad. Their larger environment, i.e., administration and management, surrounds them in their clinical day-to-day work, which can impact morale and therefore the therapy experience. How organizations treat clinicians can affect how clinicians treat their clients—perhaps not in overt ways, but in unconscious communication that can

erode and even severe the therapeutic connection.

The problem of missed appointments in outpatient psychiatric clinics is not easily resolved. It requires individual clinicians and managers to form a joint venture to more fully engage and nurture those who seek our help.

Appendix A

Informed Consent Forms

Individual Consent for Participation in Research (Consent for First Set of Participants)

INSTITUTE FOR CLINICAL SOCIAL WORK

I, _____, acting for myself, agree to take part in the research entitled: "**The Clinician's Influence on the Missed Appointment Rate in Outpatient Psychiatric Clinics: What Clinicians Think".**

This work will be carried out by Barbara Sadauski, LCSW-C (Principal Researcher) under the supervision of Dennis Shelby, Ph.D. This work is conducted under the auspices of the Institute for Clinical Social Work; At Robert Morris Center, 401 South State Street, Suite 822, Chicago, Il 60605; 312-935-4235.

Purpose

The purpose of this study is to conduct research in order to determine what clinicians believe about their influence on the missed appointment rate in outpatient psychiatric clinics. What qualities, characteristics, attitudes and behaviors of clinicians do clinicians think influence the rate at which clients show up for their appointments? This work will provide valuable information which may guide schools of social work in their training of clinicians and also which may assist organizations with improving attendance rates in their clinics.

PROCEDURES USED IN THE STUDY AND THE DURATION

Participants will be asked to participate in one to two interviews of 45-60 minutes in duration each over a period of two months. Open-ended questions will prevail. A structured demographic questionnaire will provide contextual information for the study.

Benefits
Benefits to the participant include the opportunity to share one's experience with the researcher.

Costs
The costs involve the time spent in interviews for those who participate in the live interviews.

Possible Risks and/or Side Effects

Risks include the inconvenience of taking time out of their work day to be interviewed. This may be an inconvenience to some participants. To offset this inconvenience, the researcher will ask administrators to allow participants free time to be interviewed. This will be time that will be deducted from any time required for therapeutic activity which is often counted as productivity. Other risks might include clinicians' discomfort during the interview in describing their characteristics, prior therapy experiences, and so forth.

Participants will be notified that the interview may be terminated at any time, upon their request. In addition, participants will be informed that they are free to decline to answer any question posed to them.

Privacy and Confidentiality
Interviews will be tape-recorded and identified by a code name, not by the real name of the participants. Tape recordings will be erased after the completion of the study. Names of participants will not be divulged to anyone.

Subject Assurances
By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.
I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.
If I have any questions about the research methods, I can contact Barbara Sadauski, LCSW-C (Principal Researcher) or Dennis Shelby, Ph.D.(Dissertation Chair/Sponsoring Faculty), at this phone number: 312-935-4235.

If I have any questions about my rights as a research subject, I may contact Daniel Rosenfeld, Chair of Institutional Review Board; ICSW; At Robert Morris Center, 401 S. State Street, Suite 811, Chicago, Il 60605, 312-935-4235.

Signature

I have read this consent form and I agree to take part in this study as it is explained in this

consent form.

_____ _____

Signature of Participant Date

I certify that I have explained the research to _____ (Name of subject) and believe that they understand and that they have agreed to participate freely.

I agree to answer any additional questions when they arise during the research or afterward.

_____ _____

Signature of Researcher Date

Individual Consent for Participation in Research (Consent for Second Group of Participants)

INSTITUTE FOR CLINICAL SOCIAL WORK

I, _____, acting for myself, agree to take part in the research entitled: "**The Clinician's Influence on the Missed Appointment Rate in Outpatient Psychiatric Clinics: What Clinicians Think".**

This work will be carried out by Barbara Sadauski, LCSW-C (Principal Researcher) under the supervision of Jennifer Tolleson, Ph. D, Committee Chairperson.

This work is conducted under the auspices of the Institute for Clinical Social Work; At Robert Morris Center, 401 South State Street, Suite 822, Chicago, Il 60605; 312-935-4235.

Purpose

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Benefits

Benefits to the participant include the opportunity to share one's experience with the researcher.

Costs

The costs involve the time spent in interviews for those who participate in the live interviews.

Possible Risks and/or Side Effects

Risks include the inconvenience of taking time out of their work day to be interviewed. This may be an inconvenience to some participants. To offset this inconvenience, the researcher will ask administrators to allow participants free time to be interviewed. This will be time that will be deducted from any time required for therapeutic activity which is often counted as productivity. Other risks might include clinicians' discomfort during the interview in describing their characteristics, prior therapy experiences, and so forth. Participants will be notified that the interview may be terminated at any time, upon their request. In addition, participants will be informed that they are free to decline to answer any question posed to them.

Privacy and Confidentiality
Interviews will be tape-recorded and identified by a code name, not by the real name of the participants. Tape recordings will be erased after the completion of the study. Names of participants will not be divulged except in circumstances where the participant gives permission for administrators of their clinic to know that they participate so that they can be granted work time to be interviewed. Participant should initial here_____if they agree that their program administrator(s) can be informed of their participation.

Subject Assurances
By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Barbara Sadauski, LCSW-C (Principal Researcher) or Jennifer Tolleson, Ph.D. (Dissertation Chair/Sponsoring Faculty), at this phone number: 312-935-4235.

If I have any questions about my rights as a research subject, I may contact John Ridings, Ph.D., Chair of Institutional Review Board; ICSW; at Robert Morris Center, 401 S. State Street, Suite 811, Chicago, Il 60605, 312-935-4235.

Signature

I have read this consent form and I agree to take part in this study as it is explained in this

consent form.

_____ _____

Signature of Participant Date

I certify that I have explained the research to _____ (Name of subject) and believe that they understand and that they have agreed to participate freely.

I agree to answer any additional questions when they arise during the research or afterward.

I certify that I have explained the research to_____ (Name of subject) and believe that they understand and that they have agreed to participate freely.

I agree to answer any additional questions when they arise during the research or afterward.

_____ _____

Signature of Researcher Date

Appendix B

Recruitment Materials

Distribution of Information to Managers at Community Behavioral Health Meeting

TO: CBH CEO's and Board Members

FROM: Barbara Sadauski, LCSW-C

RE: Research Study on Missed Appointment Problem

DATE: November 3 & 4, 2011

Please feel free to read the following summary of research which I plan to conduct about the missed appointment rate in community psychiatry clinics.

I am seeking participants for this study and would like to find programs which would allow me to conduct this in their organizations.

I will be here for the two days, but will not be staying overnight. Below is my contact information. I welcome your questions and interest.

Barbara Sadauski, LCSW-C
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Below is the material that was attached to this memo. Some of the specifics of the proposed research were not carried out; for example, some respondents were not social workers, but were clinicians in a clinic setting. Also, participants were not asked about their average missed appointment rate or their hobbies and interests.

Research Title: The Impact of the Person of the Clinician on the Missed Appointment Rate in Outpatient Psychiatric Clinics: What Clinicians Think

Purpose

The purpose of this study is to investigate how clinicians view their impact on the missed appointment rate in community psychiatric clinics. What do clinicians believe about their influence on clients' willingness to attend therapy sessions regularly? What factors do they believe are important—what personal characteristics and behaviors, regardless of theoretical orientation, do they articulate? The no-show rate in community mental health clinics is high and not well understood. This is problematic because clinician time is not well-spent and opportunities to serve other clients is limited when appointment times are left unfilled. This failed appointment may indicate that the client is not being served as well as is possible because people speak with their feet about how well their needs are addressed. In addition, it is important to be fiscally efficient and payment for services decreases with missed appointments. If certain aspects of the clinician's involvement with the patient have an effect on kept appointments, this is valuable information.

Significance of the study

A better understanding of this issue might lead to administrative changes in these programs such as reducing caseload sizes, establishing different criteria for hiring clinicians, or developing training programs geared toward eliminating factors that contribute to the problem. More research is needed to understand the effect of clinician qualities, characteristics, attitudes, and behaviors on the attendance rate/retention rate of clients who are enrolled in mental health treatment. This study aims to elicit clinicians' thoughts on the issue. Do clinicians feel they play a significant role in effecting client attendance? Focus on this aspect of the therapy has been neglected and yet we see the growing popularity of

"evidence-based" treatments. However, we may want to consider the importance of developing and training "evidence-based" therapist, those who attend to the clinical relationship, and use it an integral part of treatment. This study assumes that how clinicians view their impact on retaining clients is an important factor in producing what they expect.

Client retention in outpatient mental health clinics is a problem in many centers. Low attendance rates decrease the possibility of client improvement by interfering with the flow of the treatment process and by shortening the length of treatment, for those who drop-out prematurely. Low attendance rates affect the fiscal health of the institution, and subsequently, the potential for serving a greater number of clients. The rate can vary widely among clinicians. Psychiatric treatment can be difficult and painful. Factors which contribute to client retention have been studied to some extent. Many of the studies have focused on client diagnoses, socioeconomic status, and client characteristics, but not on clinician factors.

Research Strategy

Interviews with 15 social work clinicians at community psychiatric clinics located in Maryland will be conducted. These will be therapists working with adult patients. Therapists of any ethnic group, sexual orientation, or age will be invited to participate on a voluntary basis. Their help in understanding the critical role of the clinician in client retention will be solicited. One to two interviews will be conducted with each participant in order to fully capture the nuances of each person's character and attitudes, to rule out responses which might be influenced by the idiosyncrasies of the specific day and time selected for the interview. The specific settings and environment in which the clinicians work will be described so that the responses can be contextualized and more fully understood. Open-ended questions will be asked in order to fully capture the essence of the participants' responses.

Participants will be informed of the nature of the study and asked to talk about their patients and the regularity of their attendance at clinic appointments. They will be asked to talk about their interest in their work, their training, personal therapy experiences, their feelings about their patients, their opinions about patients' compliance with appointments, and anything else that is related to their clients and their attitudes toward their clients. Demographic data will be asked of each participant, including such items as years as a clinician, marital status, personal therapy experience, hobbies, and outside interests. Clinicians will be asked about their average missed appointment rate (by selecting a category with rages of rates) as well as the diagnostic mix of each clinician's caseload.

Fliers Given Out at a Staff Meeting at One Clinic to Recruit Participants

"The Clinician's Impact on the Missed Appointment Rate in Outpatient Psychiatric Clinics: What Clinicians Think"

The missed appointment rate in outpatient psychiatric clinics is something of concern to organizations which aim to optimize their resources and provide high quality care to those who seek treatment in their programs. There are various ideas about this phenomenon, but a common aim is to work to decrease this rate.

This is a research project which aims to explore a possible component of the missed appointment rate in outpatient psychiatric clinics. Clinicians who volunteer will be asked to participate in 1-2 interviews of 45-60 minutes' duration. Informed consent will be obtained from all participants.

- Participants' privacy will be protected at all times.
- There will be a small monetary compensation to offset the time that participants will be engaged in the interview(s).
- Participants may withdraw from the study at any time.
- Results of the study will be shared with participants.

Fr more information about this study, please contact:

Barbara Sadauski, LCSW-C
410-916-1315
410-788-8219
darlajean321@verizon.net

Appendix C

Interview Guides

Initial Version

- As a beginning, tell me about your work here in this clinic.
- What do you like and what do you dislike?
- Are there any particular types of clients that you prefer to work with or any that you do not want to work with?
- I'm really interested in learning about therapists' thoughts and decisions around missed appointments and one's therapeutic relationship with a client. Tell me about a client or two who have missed appointments and what you think about these situations.
- How do you feel about yourself and toward the client when they miss an appointment?
- Tell me what you say to these clients when they return to a session after an appointment has been missed.
- What kinds of things can help to reduce missed appointments?
- What are your thoughts about the therapeutic relationship and what helps to form a good therapeutic relationship?
- What behaviors, attitudes or qualities of yours might help a client keep appointments?
- Tell me if your performance evaluation, supervisor comments, pay, or other things are affected by the number of appointments clients keep

Revised Interview Guide

- Tell me about your duties here in the clinic.
- What do you like and what do you dislike?
- Tell me about your experiences with missed appointments with your clients.
- Tell me about a client who has missed appointments and what you think about the reasons they miss.
- How do you feel about yourself when clients miss appointments?
- How do you feel toward clients when they miss appointments?
- Tell me how you respond to clients after they miss appointments.
- What kinds of things do you to help reduce missed appointments? Do these things work?
- Describe qualities or characteristics of yours that can influence clients keeping appointments.
- Are there things that might cause clients to miss appointments?
- I wonder if and how nonverbal behaviors of a therapist might influence a client keeping an appointment. Can you comment on this? (Can ask follow-up questions, such as being tired or being upset and how that might influence interaction with clients. Also, personal life might affect such.)
- Describe a good therapeutic relationship. How might a good therapeutic relationship help clients keep appointments?
- Tell me how your work environment might influence your ability to keep clients engaged in treatment.

- Tell me how management expectations might influence your ability to keep clients engaged in treatment.

Note: I will follow up with statements such as, “This population…” or other stereotypical statements made by the interviewee.

Appendix D

Demographic Questionnaire

Clinicians' Experience of Their Impact on Missed Appointments in

Outpatient Psychiatric Clinics

1. What is the highest level of school you completed or the highest degree you have received?

_____Bachelor degree

_____Graduate degree (specify, Master's or Ph.D.)

2. What is your professional certification?

_____R.N.

_____LCPC

_____LCSW/LCSW-C

_____Ph.D.

_____M.A.inPsychology

_____Other (specify)

3. What types of individuals do you see here (by diagnosis) and give approximate percentage in each category.

_____Anxiety Disorders

_____Depressive Disorders

_____Schizophrenia

_____Bipolar Disorder

_____Mood Disorder

_____Adjustment Disorders

_____Personality Disorders

4. How many cases do you currently have?_____

5. How long have you worked as a clinician?

_____under one year

_____1-3 years

_____4-7 years

_____8-15 years

_____over 15 years

6. How long have you worked at this clinic?

_____under one year

_____1-3 years

_____4-7 years

_____8-15 years

_____over 15 years

7. Have you ever had your own personal therapy experience?

_____yes

_____no

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