



Building Fences:

An Investigation into Psychotherapists' Experience of Developing Boundaries

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Abstract

Boundaries are considered fundamental to the work of psychotherapy. Current literature shows that good boundaries provide a safe space for both the client and the therapist. There is significant writing on the risk and consequence of boundary violations. And yet, current research sheds very little light on the essence of boundaries. Using an Interpretative Phenomenological Analysis, this qualitative study offers insights into the experience of three psychotherapists, as they developed boundaries in their work as therapists. Three themes emerged: “boundary: a blanket term”, “what lies beneath: hidden behind boundaries” and “contamination”. It is found that that the word “boundary” is used broadly, to describe many different phenomena. Consequently, the word “boundary” is used to hide feelings which are uncomfortable for the therapist. The final theme is the concept of the psychotherapists’ personal-lives being contaminated by their work as therapists.

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“Before I built a wall I’d ask to know
What I was walling in or walling out”

- Robert Frost

Chapter 1: Introduction

1.1 Background and Context

The poet Robert Frost (1914/2012) wrote that “good fences make good neighbours” (p. 2). An awareness of one’s boundaries and limits is critical to developing healthy relationships, for it is at these boundaries that interaction with others takes place. (Whitfield, 1993).

In the psychotherapeutic setting, research has shown that it is the relationship between therapist and client, beyond all other factors, that determines the successful outcome of the process (Whiston & Sexton, 1993; Clarkson, 2003). Like all relationships, this relationship is dependent on healthy boundaries, and it is the role of the psychotherapist to establish and maintain these boundaries (D. Smith & Fitzpatrick, 1995).

The process for developing healthy boundaries in humans has been the focus of much research; children require a care-giver, a secure-base and a holding-environment in which their feelings are met and regulated (Bowlby, 1958; Winnicott, 1960; Ainsworth & Bell, 1970). It is in this context that children begin to understand the first boundary, the division between that which belongs to them, and that which does not. The development of boundaries begins in infancy, and continues throughout life.

Alongside the literature showing the importance of boundaries is a wealth of research which warns of the consequences for the psychotherapist in violating boundaries (Schwartz & Olds, 2002; Glass, 2003; Akhtar, 2006; Audet, 2011). Literature and guidelines also state that it is the responsibility of the psychotherapist

to set and manage boundaries in the therapeutic relationship (Gutheil & Gabbard, 1993; 'IACP Code of Ethics and Practice for Counsellors / Psychotherapists', n.d., 'IAHIP Code of Ethics for Psychotherapists', 2010).

While current research highlights the importance of boundaries in psychotherapy and gives stark warnings about the risk and implications of violating these boundaries, much less is written about the nature of boundaries (Gutheil & Gabbard, 1993). Boundaries may defy definition because they are subjective, artificial, man-made constructs (Wilber, 2001; Dineen, 2002). The subjective, experiential nature of boundaries means that therapists learn about boundaries by coming into contact with them, and sometimes by crossing them (Barratt, 2015).

The word "boundary" can be used to describe a dividing line between entities or the limit of an activity. The literature also points to different kinds of boundaries; those which are structural, psychological, interpersonal, content-related, limit-defining and rule-based (D. Smith & Fitzpatrick, 1995; Gutheil & Gabbard, 1998; Dineen, 2002). The word is therefore used broadly in psychotherapy, which may contribute to the lack of research on the nature of boundaries.

There appears to be a bind here for trainee psychotherapists, who are responsible for managing boundaries in the therapy room. While boundaries are understood to be core to psychotherapeutic work, and the consequences of violating boundaries are shown to be dire, there is a lack of clarity on the nature of a boundary. This is the backdrop for the current research, which aims to investigate the experience of psychotherapists of developing boundaries in the work. If boundaries are subjective, then they are best understood by exploring the lived-experience of psychotherapists.

1.2 Aims and Objectives

The aim of this research is to investigate pre-accredited and recently accredited psychotherapists' experience of developing boundaries, as they begin therapeutic work with clients. The research will attempt to understand the lived-experience of psychotherapists, and to explore how these psychotherapists make sense and find meaning from their experience.

The specific objectives of this research are:

1. To review the current literature on boundaries in psychotherapy.
2. To explore the experience of pre-accredited psychotherapists, as they develop boundaries in the therapeutic work.
3. To contribute to existing theory.

Chapter 2: Literature Review

2.1 Introduction

This literature review explores current research on boundaries in the psychotherapeutic relationship. The review begins with several definitions of boundaries, then explores how boundaries are developed in childhood. The psychotherapeutic relationship is then explored, and the importance of boundaries in this relationship is shown. Literature is presented which highlights the risk and implications of violating these boundaries. Self-care for psychotherapists is reviewed through the lens of boundaries. An exploration is then given on the experience of therapists in developing boundaries.

The literature review concludes by contrasting the abundance of literature on the importance of boundaries with the lack of research on the nature of boundaries. This juxtaposition sets the context for the current research paper.

2.2 Defining Boundaries

While it may be relatively straightforward to evoke a sense of what a boundary is, it is difficult to define a boundary (Gutheil & Gabbard, 1993; Piovano, 2008). The Oxford Online Dictionary (n.d.) defines a boundary as being “a line which marks the limits of an area; a dividing line”, or “a limit of something abstract, especially a subject or sphere of activity”. In relation to the limits of an activity, Barratt (2015, p. 207) notes that while it is often straightforward to deem an action appropriate or inappropriate, it is more challenging to determine exactly where or why a boundary of appropriateness should be placed. Therefore, while the presence or absence of a boundary may appear obvious, the exact nature of a boundary is difficult to define.

In terms of human relationships, boundaries can be described as the area where interaction with others takes place, thus boundaries are at the core of relationships (Whitfield, 1993). Schwarz and Olds (2002) argue that in a relationship, two people are always either moving closer together or moving further apart (p. 482-483). This constant movement is required to keep intimacy and closeness alive. Therefore, the boundary between people is dynamic; it is something that changes over time.

Dineen (2002) notes that like fences, boundaries are “artificial and arbitrary”, and can be built, removed or changed at any time (p. 119). Wilber (2001) argues that boundaries do not exist in the physical world, but “only in the imagination of mapmakers” (p. 25). He suggests that while lines exist in the world, for example between land and sea, a line only becomes a boundary when humans imagine that each side of the line is unrelated and separated. Wilber reminds the reader that a shoreline does not just separate land from sea; it also joins land and sea. Wilber’s thesis is that people use boundaries to divide something perceived as inside from something perceived as outside. To Wilber, this never represents reality, because, in reality, both the inside and the outside co-exist. The idea of a boundary, therefore, serves an individual’s need to see things as separate, rather than as part of a whole.

In summary, the literature defines boundaries as being at the core of human relationships, as being challenging to define, and as being subjectively experienced.

2.3 Boundaries in Childhood

Gerhardt (2004, p. 22) notes that on a physiological level, an infant is essentially a part of his mother’s body. Through regulation, and by having access to a secure base and a reliable care-giver, children begin to develop a sense of their own

boundaries, which are used throughout life to navigate relationships. With good enough care, children learn that they will be soothed when they are distressed, and begin to tolerate a broader range of feelings (Bowlby, 1958; Ainsworth & Bell, 1970). There is a sense here of boundaries gradually emerging through a process of exploration.

During the oral and anal stages of development, the infant's embodied experiences help him to develop a sense of that which belongs to him, versus that which does not (Barratt, 2015). The infant begins to understand that the mouth belongs to him, while the nipple that feeds the mouth belongs to someone else. Faeces appears to belong to the infant, but then become separate, accompanied by a response from the caregiver. It is in these early experiences that children first get a sense of the question / reality of psychological boundaries.

2.4 Boundaries and the Psychotherapeutic Relationship

In the early psychoanalytic field, mixed messages were evident regarding boundaries in the therapeutic relationship (Gutheil & Gabbard, 1993, p. 189). While Sigmund Freud (1911/2001) advocated for the detachment of a surgeon, he also sent postcards to patients and gave them gifts and occasional financial support. This ambiguity, along with further mixed messages from other early key figures, may have contributed to the difficulty in defining boundaries in modern psychotherapy (Gutheil & Gabbard, 1993, p. 189).

Research has shown that beyond all other factors, it is the relationship between therapist and client that determines the successful outcome of psychotherapy (Whiston & Sexton, 1993; Clarkson, 2003). If relationship is core to our existence,

then the relationship between client and therapist can be used to explore this central component of the client's being (Kahn, 1997). Given that boundaries are core to human relationships, it follows that boundaries are core to psychotherapy (Whitfield, 1993).

Boundaries in psychotherapy can be seen as a frame or envelope, within which the roles of the participants are defined (Gutheil & Gabbard, 1993; D. Smith & Fitzpatrick, 1995). Contained in this frame are both structural elements and interpersonal elements. The structural elements define an external boundary between the psychotherapist and client, and include fees, setup of the therapy room, cancellation policy and timings of sessions. The interpersonal elements define the psychological boundary between the therapist and client, and include the relationship between therapist and client, self-disclosure and physical contact. Thus, there are at least two levels of boundary at work within the therapeutic relationship. Good external boundaries provide a solid foundation for the therapeutic relationship, by creating a safe and predictable space where the client can learn to trust the therapist and disclose difficult material. These external boundaries allow for crossings of psychological boundaries in a safe environment, through mechanisms such as projection, empathy and projective identification.

While, as has been stated, boundaries are difficult to define, it is the job of the psychotherapist to manage these boundaries (Gutheil & Gabbard, 1993). A therapist must stay sufficiently close to the client's experience to be affected by it, while also maintaining enough distance to be able to function effectively as a therapist (Casement, 2013). The boundary, then, is something flexible, to be worked with by the therapist, while maintaining a curiosity about it.

Lott (1999) notes the difficulty in maintaining hard boundaries while remaining authentic. If boundaries are too rigid, then there is potential for the human response to be lost. She suggests that boundaries should be negotiated rather than fixed. Geist (2008) states that there must be a permeable boundary between therapist and client. The author argues that the client can only come to a position of self-empathy and self-understanding if the boundaries can be made permeable enough to allow both therapist and client to share a feeling of vulnerability.

2.5 Self-Disclosure

Research suggests that the use of self-disclosure is one of the most conflicting issues across the various therapeutic approaches (Gibson, 2012). A boundary exists between that which is private for the therapist and that which is not (Pietkiewicz & Włodarczyk, 2015, p. 708). Gibson (2012) argues that in psychotherapy, as in all of life, people are constantly disclosing information about themselves. Using the model of the Johari window, the author notes the impossibility of never self-disclosing in a therapeutic relationship. The therapist's self-disclosure is not limited to words; information is also communicated in facial expressions, clothing, and setup of the therapeutic space.

In terms of self-disclosure, it appears that therapists disclose more about themselves to clients who they perceive to be more stable or less symptomatic (Kelly & Rodriguez, 2007). Also, experienced therapists are likely to disclose more than recently qualified therapists (Gibson, 2012). This raises a question about training versus professional experience, and how therapists' views on boundaries shift as they gain experience working with clients. The authors note that further investigation is warranted on this question.

It is interesting to note that psychodynamic psychotherapists say that they disclose information less frequently than humanistic psychotherapists (Henretty & Levitt, 2010). While psychodynamic psychotherapists are unlikely to share personal stories with clients, the psychodynamic approach does involve the therapist exploring her feelings in the immediacy of the relationship, and making a decision on whether to communicate these feelings to the client (Jacobs, 2010).

In the internet era, psychotherapists have another boundary to manage with regards to self-disclosure (Zur, Williams, Lehavot, & Knapp, 2009). While the impacts of internet-disclosure are still not fully understood, psychotherapists' personal information is becoming more available to clients. In engaging with social media, the psychotherapist is now making decisions around what to disclose to clients.

2.6 Words of Warning

The literature contains many cautionary notes about boundaries. Lott (1999) describes psychotherapy as "a fragile, paradoxical relationship always at risk of turning into something else" (p. 78). Schwarz & Olds (2002) suggest that psychotherapy has an inherent tendency to move towards boundary violations, given the experiences of closeness in the therapy room, the vulnerability of the client and the lack of witnesses to the process.

Boundaries can potentially be self-serving for the psychotherapist, designed to protect and empower the therapist, rather than the client (Dineen, 2002, p. 119). Fay (2002) goes as far as to argue that in psychotherapy, there is a stronger case for not having boundaries than for having boundaries, observing that boundaries can serve to obstruct the process of healing by creating a distance between therapist and

client. Therefore, there is an onus on the psychotherapist to ensure that the boundaries are there to empower the client, rather than the therapist. This is challenging, given that the therapist holds the majority of the power in the relationship, particularly in the early stages of the process (Proctor, 2014, p. 155).

Gutheil & Gabbard (1998) differentiate between boundary violations and boundary crossings. With a boundary crossing, there is no harm to the client and the physical contact usually arises from a normal and spontaneous human response to a situation. An example would be if a client had received some very bad news before a session, arrived very upset and reached out to hug the therapist, and the therapist responded by hugging the client. The authors note that not responding to such a situation might damage the client and the therapeutic process. Quite often, boundary crossings are discussed by the therapist and client, and are used for the benefit of the therapy. The therapist and client, on the other hand, rarely discuss a boundary violation. Boundary violations are damaging or exploiting for the client, an example being a therapist who hugs the client at the end of every session, or who repeatedly burdens the client with personal disclosures. When considering boundary issues, a key question for therapists is whether each action serves the client's therapeutic interests.

While both therapist and client may participate in boundary violations and crossings, it is generally agreed that it is the therapist who is responsible for establishing and maintaining boundaries (D. Smith & Fitzpatrick, 1995). In the Irish context, both the Irish Association of Humanistic and Integrative Psychotherapists (IAHIP) and the Irish Association for Counselling and Psychotherapy (IACP) explicitly state in their codes of conduct that it is the psychotherapist's responsibility to set and manage the

boundaries in the psychotherapeutic relationship ('IACP Code of Ethics and Practice for Counsellors / Psychotherapists', n.d., 'IAHIP Code of Ethics for Psychotherapists', 2010). The development of boundaries is therefore a core element of becoming a psychotherapist.

Overall, the literature emphasises the fragility of psychotherapeutic work, and the risk and implications of boundary violations. Boundaries, which are managed by the psychotherapist, are identified as a means to prevent this from happening.

2.7 Boundaries and Self-Care

Norcross & Guy (2007) state that boundaries in psychotherapy exist to provide a predictable, safe space for both the client and the therapist (p. 94). The authors note that by focusing too heavily on maintaining boundaries, behaviours that are overly rigid can emerge. While the authors advocate strongly for boundaries, they also note the importance of flexibility within these boundaries.

The literature points to the potential for disruption in a psychotherapist's personal-life, while working with difficult material in the therapy room (Norcross & Guy, 2007). It may be helpful to mark the boundary between work-life and personal-life, using rituals or activities such as meditation, prayer, exercise or a change of clothes (Neumann & Gamble, 1995). When working with clients with severe disturbances, it may be unrealistic for a therapist to leave the work in the therapy room. To stay well, it is important for therapists to have a rich and joyful life outside of their role as psychotherapists (Norcross & Guy, 2007, p. 108).

Countertransference and compassion-fatigue can both result in a therapist's personal-life becoming disturbed (S. Freud, 1910/2001; Figley, 2002; Beaumont,

Durkin, Hollins Martin, & Carson, 2016). While countertransference is normally related to a therapist's past experiences, compassion-fatigue is more closely related to the therapist empathising with the experiences of the client. Compassion-fatigue is closely related to vicarious trauma, where a care-givers beliefs or schemas are disrupted as a result of working closely with people who have experienced trauma (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995).

In order to avoid compassion-fatigue, it is important that therapists find ways to disengage from their clinical work (Figley, 2002, p. 1438). Disengaging involves a conscious effort on the part of the therapist to let go of the feelings, sensations and thoughts associated with client-sessions. While empathy is enormously beneficial for the client, there is also an emotional cost to the therapist. The author suggests that this cost is only understood through experience, and it is only with experience that therapists will begin to draw boundaries around how much empathy they are willing to offer.

Although stress and anxiety are common among psychotherapists, they are likely to over-personalise these feelings due to a sense of shame (Norcross, 2000, p. 710). Indeed, the profession of psychotherapy has tended to stigmatise the idea of therapists as wounded-healers, who struggle with difficult feelings (Zerubavel & Wright, 2012, p. 488). The authors question why it is that psychotherapists are often uncomfortable with the woundedness of their peers, while at the same time trying to normalise these struggles in their client's lives. The authors propose that this incongruence is linked to a concern by therapists about appearing incompetent or even unstable among their peers.

2.8 The Experience of Developing Boundaries for the Therapist

Considering the importance given to boundaries in the literature, and the emphasis on the risk of these boundaries being violated, it is surprising that so little research has been conducted on the nature of boundaries (Barratt, 2015, p. 206). Outside the therapy room, Petronio (2002) argues that boundaries are developed socially. This ties in with the findings above that boundaries are subjective, and that therapists develop boundaries through experience rather than through training.

The literature explores how therapists should respond to boundary challenges and crossings. When making boundary decisions, Pope & Keith-Spiegel (2008) advise paying attention to “uneasy feelings, doubts, or confusions” (p. 642). In psychodynamic psychotherapy, when confronted with a boundary issue, Bridges (1999) describes the therapist’s role as trying to understand what is being communicated in the interpersonal relationship in that moment. Developing and maintaining boundaries appears therefore to be based on felt-experience and exploration, much like the development of boundaries in childhood. Each boundary-contact and boundary-crossing presents an opportunity for re-negotiation and refinement of boundaries.

Therapists frequently use their professional experience to develop an understanding of boundaries, when this has not formed part of their formal training (Pietkiewicz & Włodarczyk, 2015). The authors note that this process has not been examined, although it is likely that therapists reflect upon chance encounters, and unconsciously identify with peers and supervisors.

Pietkiewicz & Włodarczyk (2015) draw an analogy between celebrities and psychotherapists, noting that both hold a special status with fans and clients

respectively. The authors note that celebrities tend only to consider the boundary of privacy when they become famous, and suggest that the same could be said for psychotherapists. In beginning the clinical work, the boundary of privacy comes under the spotlight, as the psychotherapist grapples with self-disclosure and accidental meetings. The authors also note that further research is required into how therapists identify certain items as private.

Barratt (2015) uses conscience as an analogy for psychological boundaries. The author questions how a person would know they had a conscience unless they did something which led them to experience guilt. In the same way, perhaps a psychotherapist needs to bump against, and occasionally cross over, boundaries, to get a sense of their nature. This may explain the absence of writing on the nature of boundaries; they are subjective and can only be understood through experience.

2.9 Conclusion

Overall, the research points to the importance of boundaries in the psychotherapeutic setting. Relationship is core to psychotherapy, and good boundaries are core to relationships. The literature frequently mentions the hazards of violating boundaries, and highlights the fragility of the therapeutic relationship, always in danger of becoming something else.

Despite the emphasis on the importance of boundaries in psychotherapy, and on the consequences of boundary violations, there is a lack of research on the nature of boundaries, and on how they are developed (Barratt, 2015). The author notes that much of the writing on the nature of boundaries is in the pop-psychology genre, and is focused on co-dependency and on 'how to say no'. The author also suggests that

psychological boundaries cannot be defined absolutely, but only in context, and relative to other boundaries. While therapists are generally certain that boundaries should exist, they tend to be unsure as to exactly where this boundary should be placed.

It is suggested in the research that boundaries are dynamic, and are developed experientially and relationally, as therapists push against and sometimes cross them in the therapeutic relationship. Because boundaries are developed experientially and always exist in a context and a relationship, they seem to defy definition.

Boundaries appear to be subjective and context-specific, and to be developed over time via the experience of the psychotherapist and the client. Despite their importance, little is written about their nature. Given their subjective nature, boundaries are best understood through experience. This research sets out to explore the experience of recently accredited and pre-accredited psychotherapists, as they begin to develop boundaries in the psychotherapeutic setting.

Chapter 3: Methodology

3.1 Introduction and Methodological Approach

The methodology chapter outlines the process of conducting the research. Firstly, the research design and sample selection is discussed. The methodology for collecting and analysing data is then reviewed, followed by an overview of ethical issues.

This research paper aims to understand the lived-experience of people as they develop in the role of psychotherapists. As shown in the literature review, the development of boundaries is a process that begins in infancy, and that is brought into sharp focus in the therapeutic setting. This research aims to explore the sense and meaning derived by psychotherapists as they develop their boundaries in the therapeutic relationship.

3.2 Rationale for a Qualitative Approach

Qualitative research is a process of investigation into an individual's personal experience, and into how the individual makes meaning from this experience (J. A. Smith, 2004; McLeod, 2014). Via a process of deep engagement in an aspect of life, the qualitative researcher aims to build on theory by capturing the totality of the experience and attempting to understand it (McLeod, 2001). The literature review has shown that boundaries themselves are complex phenomena, easier felt than understood. The lived-experience of developing boundaries as a psychotherapist is therefore likely to be highly nuanced, subtle and complex, and to be unique to each psychotherapist. Qualitative research has been shown to be highly effective for such in-depth explorations of areas of complexity (Brocki & Wearden, 2006). Qualitative

research uses detailed and rich data to produce understandings that are rounded and appropriate to the context (Mason, 2002, p. 3).

3.3 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) has an emphasis on how people make sense of their experiences (J. A. Smith & Osborn, 2003). It involves a two-fold process or double-hermeneutic: while the participant tries to make sense of his/her experience, the researcher tries to make sense of the participant's sense-making. The researcher tries to come as close as possible to the participant's lived-experience, noting what is being said and not being said, that which the participant is aware of and that which may be outside the participant's awareness. In this way, IPA resembles the process of psychotherapy, as the researcher tries to come into contact with the participant's experience.

In this research, IPA was used to create an understanding of the lived-experience of a group of psychotherapists as they develop boundaries in the work, and to investigate how they make sense and meaning from this experience. The process of developing boundaries may be inside or outside of the participants' conscious awareness, and it is conceivable that participants may have made very little sense of the process. For these reasons, the researcher attempted to derive meaning and sense from the participant's sense-making and struggles, and to tune into what was being expressed in the interview, how it was expressed, and also what was not expressed.

Because each interview resembles a therapeutic encounter, the researcher attempted to understand and make sense of the boundary between interviewer and

interviewee. The interviewer asked the interviewee how he/she experienced the interview, and attempted to make meaning of his own experience of boundaries in the interview.

3.4 Sampling

When using IPA, it is preferable to work with a relatively homogenous sample (Smith & Osborn, 2003). The sampling should be purposive, being used to select a group for whom the topic is of significance.

The first decision regarding the sample was the orientation of the psychotherapists. Given the desire for homogeneity, it made sense to work with psychotherapists who have a similar orientation. Based on the orientation of the researcher's training, a decision was taken to work with psychotherapists who work in a humanistic-integrative or psychodynamic way.

There were two schools of thought regarding the levels of therapeutic experience of the sample. IPA relies on the ability of the participants to accurately describe their experiences and thoughts (Brocki & Wearden, 2006). On one hand, a participant who has recently begun work as a psychotherapist would have a more recent memory of initial experiences of developing boundaries in the therapeutic work. However, an experienced psychotherapist would likely have had more opportunity to reflect upon and make sense from this process, and may have been better able to articulate the experience. On balance, it was decided to work with psychotherapists who were pre-accredited or recently accredited. These therapists were still relatively close to the initial experience of developing boundaries in the work, and had also

completed the clinical-hours and reflections required to graduate from their training institutes.

Given the in-depth nature of IPA, it is recommended that a small sample group is used (J. A. Smith, Flowers, & Larkin, 2009, p. 51). The authors recommend a sample-size of three for a Masters-level study. This number allows for a detailed analysis on each case, as well as an exploration on the differences and similarities between cases. For these reasons, a sample size of three was chosen for this research.

Participants were identified from two main sources. The researcher was working as a trainee in a therapy centre in Dublin city, and the clinical manager of this centre provided introductions to a group of pre-accredited and recently accredited psychotherapists. The course-head at the researcher's training institute also provided introductions to recent graduates from a Masters in Counselling and Psychotherapy, who had stated a willingness to be involved in research projects. From these pools, three psychotherapists expressed a willingness to take part in the research project. Although this was not part of the design, it transpired that all three participants had attended the same training institute.

Each participant completed a demographic sheet, shown in Appendix 3, prior to the interview. Table 1 below shows an overview of the demographics of the sample.

Table 1: Demographics of Participants

Pseudonym	Frances	Michael	Amy
Gender	Female	Male	Female
Age Group	40-45	40-45	35-40
Years Practicing	2 years 6 months	4 years 7 months	1 year 10 months
Client Hours (approximate)	360	1000	600
Accreditation	Accredited	Accredited	Pre-Accredited
Orientation of Core Training	Humanistic and Integrative	Humanistic and Integrative	Humanistic and Integrative

3.5 Quality and Validity

Yardley (2000) defines four principles for ensuring the quality and validity of quantitative research: “sensitivity to context”, “commitment and rigour”, “transparency and coherence” and “impact and importance” (p. 219). In this research, sensitivity to context was achieved by reviewing previous literature on the area, by the process of choosing IPA as the most suitable methodology, and by the focus and attention given to interviews and analysis. Commitment and rigour were demonstrated in the attentiveness shown in interviews, in the choice of questions and in the selection of the sample. Transparency and coherence were displayed in the outline of the research process, and in the consistency of the arguments presented. This research

aspires to have impact and importance, in that it is intended to contribute to the literature on boundaries, and to give the reader an insight into the experience of developing boundaries for the psychotherapist.

In the interests of transparency, it is noted that the researcher works in the same therapy centre as one of the research participants. While not well known to each other, they occasionally meet in the common-room. The researcher has been conscious of forming an opinion of this participant via these encounters, and has attempted to place a boundary around opinions formed outside of the research interview.

3.6 Data Collection: Semi-Structured Interviewing

Semi-structured face-to-face interviews were used to collect data for this research. Semi-structured interviews aim to obtain an understanding of the participant's lived-experience, with a view to interpreting the meaning of the experience described (Kvale, 2007, p. 11). Semi-structured interviews give the researcher a good schedule to work with, but also allow for the development of rapport with the participant, and allow areas of interest to be pursued (J. A. Smith & Osborn, 2003). When using IPA, it is helpful to allow the interview to flow in this way, following the participants as they attempt to make meaning from their experiences.

A set of guide questions were developed in advance of the interviews, and these were tested with peers and supervisors. A pilot-interview was also conducted with a peer. Questions were designed to be open, and to avoid steering the participants in any direction (Kvale, 2007). Prompts were considered for questions, so that a "gentle nudge" could be given to the participant if answers were not forthcoming (J. A. Smith

& Osborn, 2003, p. 61). The interview questions followed a funnelling approach, beginning with very general questions and working into more detail about the therapist's experience of boundaries (J. A. Smith & Osborn, 2003, p. 62). The funnelling approach helped to create a sense of comfort in the room by starting off generally, encouraging participants to speak openly, before focusing in-depth on one area. Follow-up questions were added, to be asked in response to participant's initial answers (Kvale, 2007). Guide questions, including follow-up questions, are shown Appendix 4.

Each interview was digitally recorded and transcribed verbatim. Interviews lasted approximately forty-five minutes, and were conducted in private, either in a therapeutic environment or an office meeting-room. Field-notes were recorded by the researcher immediately following each interview, in order to capture the researcher's lived-experience of the interview.

3.7 Data Analysis

Following the transcription of the interviews, each interview was separately analysed (J. A. Smith et al., 2009). Following multiple readings of each interview, a line-by-line analysis was conducted, picking out the key points being made by the participant. The researcher's thoughts and interpretations were also noted on a line-by-line basis, with attention being paid to the content as well as the language used by the participant (Pietkiewicz & Smith, 2014). A sample from this analysis is shown in Appendix 5.

Following this coding, a set of themes were noted for each interview, and themes were identified which were common to all interviews. These themes were then listed

on a white-board, and all references to these themes from the interviews were enumerated. At this point, themes were grouped together so that three final themes emerged. The mapping of themes on the white-board is shown in Appendix 6.

The final listing of themes was re-checked against the interview transcripts, to ensure they were relevant to all participants. Themes were also discussed in supervision and with peers, to ensure relevance and minimise researcher bias.

3.8 Ethical Issues

The research topic is a very personal matter, exploring the lived-experience of psychotherapists as they develop into the role. It was important that participants gave “informed consent” prior to participating in the research (Kvale, 2007, p. 27). Before the interview, participants were informed about the research topic, the overall design of the research, potential risks of participating, and about their rights as a participant. This information was given in writing, and participants signed a consent-form prior to conducting the interview. The information sheet is shown in Appendix 1, and the consent form is shown in Appendix 2. Participants were invited to follow-up with the researcher with any queries or concerns.

Participants had a right to withdraw from the study at any point up to the submission of the research paper to Dublin Business School. Participants also had a right not to disclose any information during the interview. These rights were given in writing to each participant, and confirmed verbally prior to each interview.

Participants were informed that their confidentiality would be protected, and that their identities would not be disclosed. While the final research-document is publicly available, considerable care was taken to protect the anonymity of the participants.

All information related to the participants' identities was be removed from transcripts, and replaced with pseudonyms. Nobody, aside from the researcher, had access to the recordings, and these were stored in a secure digital environment. Following the submission of the research, the original recordings were destroyed.

Chapter 4: Results

4.1 Introduction

Three participants were asked about their experience of boundaries in psychotherapeutic work. Following an Interpretative Phenomenological Analysis (J. A. Smith et al., 2009) of the transcribed interviews, three themes emerged. The themes are presented below, and are illustrated with verbatim extracts from the interviews. The themes are:

1. Boundary: A Blanket Term
2. What Lies Beneath: Hidden Behind Boundaries
3. Contamination

The first two themes are closely related. The broad use of the word “boundary” meant that what was named as a boundary sometimes appeared to be a means to hide or avoid uncomfortable feelings. The third theme to emerge was contamination, which related to the boundary between work-life and personal-life.

In this chapter, each participant is identified by a pseudonym. Quotations are coded using the first letter of the participant’s pseudonym and the line number from the relevant transcript (e.g. M 97 = *Michael*, line 97).

It is worth noting that all three candidates emphasised the importance of boundaries in therapeutic work. Boundaries were described as “very, very necessary” and as being “absolutely fundamental” to psychotherapy.

4.2 Boundary: A Blanket Term

Each participant was asked about his or her experience with boundaries in therapeutic work. All participants described themselves as “boundaried”, and the word “boundaried” was used 29 times in total by the three participants.

The word “boundaried” was used very broadly, to describe many phenomena. Frances described herself as “boundaried” in her note-taking, in supervision, with her use of a home-office, with the timing, content and ending of client sessions, and with her fee and cancellation policies. Michael stated he was “boundaried” regarding erotic transference. Amy said she was “boundaried” in dealing with client issues, with client communications, with supervision, with self-disclosure and with not bringing client work into her personal-life.

The different uses of the word “boundary” are categorised below.

4.2.1 Boundaries around Client Communication

Boundaries were referred to when discussing client communication. For Amy, this meant that “I only check phones at certain times”, although when one client was experiencing suicidal ideation, Amy “loosened the boundaries” by giving the client her personal phone number. Amy also noted that the client “respected that boundary” by not calling unnecessarily. Frances described a phone call with a client during a Christmas break as being a “boundaried phone call”. The call appeared to be “boundaried” because it was once-off, because the timing was agreed upfront by text, because it was of a fixed duration, because the content was managed and because Frances took the call in her home-office, as opposed to a family-room. With respect to client communication then, the word “boundary” was used to define a

measure of how available the therapist is outside of sessions, and was also used to describe the content and context of interactions outside of sessions.

4.2.2 Boundaries and Holding

Boundaries were used to describe how a therapist creates a holding-environment in a session (Winnicott, 1960). Frances related boundaries to the idea of containment, saying “I’m very boundaried around each session having a beginning, a middle and an end”. Frances would ensure that clients realised when a session was coming to an end, and saw this as being “boundaried”.

F 33: I would say ‘we’re coming to the end of the session now in the next five minutes’, so we wouldn’t open into anything else, and that’s keeping the content of the session very boundaried.

Michael referred to a boundary around expressing emotions during client sessions, noting that while it is healthy to show empathy, it is also important to be able to hold the client’s emotions.

M 199: For me, I would like to feel it’s me accepting the client, and then to show that their emotional response is absolutely acceptable . . . And at the same time, I think it’s very important, that there is a boundary part, that if one becomes too overwhelmed by it, it would suggest that you can’t hold it, you know.

4.2.3 Boundaries Around Disclosure

Two participants spoke about boundaries around disclosing personal information to clients. Michael said that he would rarely “self-disclose”, except to give a snippet from his own life which didn’t have any identifying information. He believes that he is already giving enough away in his appearance and accent. Frances said she felt it was part of her training to not disclose much to clients, and that her own personal details “don’t need to come in”.

4.2.4 Boundaries and Relationships

The word “boundary” was also used to describe the way relationships are negotiated and understood; both the client-therapist relationship and the client’s personal relationships. Amy spoke about clients who have an “absolute lack of boundaries” in their personal relationships.

A 186: Whether it’s taking on other people’s emotions, or if it’s taking on other people’s anxieties, or this constant worry of what other people think. . . The tightening up of those boundaries, and creating those boundaries has such a powerful impact on their lives, massive impact.

Amy appeared to be identifying boundaries as being the building blocks of relationships, and to be making a link between creating boundaries in the therapeutic relationship, and the client strengthening boundaries in their personal-lives.

Michael said that he would be less likely to disclose personal information to a client who he believed had “boundary issues”, by whom he meant clients who started to see him “maybe as a friend, or something outside that”. Amy described how clients can “push your boundaries in different ways”, again in trying to shift the relationship from a professional to a personal one. The therapeutic relationship appears to have boundaries, which should not be crossed. Michael used the word “boundary” to describe the impossibility of having a dual relationship with a client, were an erotic transference to emerge.

M 220: I’m very boundaried with that, like, I have an awareness that the client is attractive, but I’m very much like, you know, I’m in a relationship anyway, and . . . therapeutic boundaries are, you know, absolutes, like. So, I know that the relationship could never happen outside of the therapeutic space.

4.2.5 Boundaries Between Work-Life and Personal-Life

Both Frances and Amy also described boundaries between work-life and personal-life. This is discussed in more detail under the theme “Contamination” in Section 4.4. Amy said she that when she isn’t working, “I actively just don’t want to be thinking about work”. Frances described her use of different clothes for client-work as being a boundary, which allows her to feel “fresher” when she isn’t working. Frances also identified a boundary within her own home, saying that it was her own “professional boundary” to avoid bringing work into any parts of her house aside from her home-office. She also stated that she would not be comfortable seeing clients in her house.

4.2.6 Practical Boundaries

The word “boundary” was also used to describe the practical aspects of the client-therapist relationship. Frances and Amy spoke about the boundaries of fees and cancellation policies, and both noted the importance of having clarity up-front on these. Amy stated that this clarity helps to keep the work steady for the client, while also protecting the therapist’s income. Michael spoke about the boundary of time, and about occasions when he allowed sessions to run over time with clients who had borderline personality disorder. Michael believed that this had a negative impact on the clients, who needed a clear boundary around the session.

4.2.7 Boundaries: Many Meanings

The word boundary, then, had many different meanings for the participants in this study. There was a sense that boundaries are important and that they are core to the work of a psychotherapist. However, as the participants began to explore the idea of boundaries, many different meanings emerged, as outlined above.

4.3 What Lies Beneath: Hidden Behind Boundaries

As well as showing a lack of clarity as to the meaning of boundaries, all participants showed a lack of clarity as to the purpose of boundaries. Boundaries which were initially identified as being for client's protection often transpired to be in place to protect the therapist.

Frances spoke about an occasion when she was shopping with her daughter, and was seen by a client.

F 161: I did meet a client outside, if we're talking about boundaries, outside of a session once. Now I didn't meet her as such, she saw me. . . she thought I saw her, I didn't. And this came into the session very strongly next time, and she would have liked to go over to me and say hi. She hoped I'd see her and say hi.

In discussing this encounter, Frances began by referring to the client's "dilemma", about whether to say hello to the therapist. As the researcher explored further, Frances said that she also felt "quite strongly" about the issue, noting "there was a bit of, for me, exposure in that". The researcher probed about this feeling of exposure, and Frances stated that the client was going through a process about her own daughter who had passed away, and Frances didn't want to "interrupt or disturb" this process. However, the researcher was left with a feeling that this sense of exposure was more significant than Frances had initially said.

There was a to-and-fro in the interview, regarding Frances' lived-experience of this encounter. As the conversation continued, the core of the issue appeared to be this feeling of exposure experienced by Frances "because I wasn't in control of it". However, it took time to get to this, and what was really a fear of exposure was

initially presented as a concern for the client. Frances could rationalise this fear by referring to her training on boundaries.

F 196: I can be very boundaried in the work, in the room, my consulting room. I don't disclose much really, I feel it's part of my training not to.

Michael spoke about how he deals with erotic transference, if he believes that a client is experiencing attraction to him.

M 235: Yeah, I think I've brought them back to their relationship, or if they're not in a relationship, I might look at something that they're presenting, which is maybe a block from a relationship . . . I've never named it, as in, you know, how do you identify me, or anything like that, cos I think that would be very threatening.

Michael said that he avoids directly naming an erotic transference, because it might feel threatening for the client. This appeared to be a healthy boundary, helping ensure the client felt safe. After more questioning, Michael talked about his own experience with a female therapist, who, early in the process, tried to "lay out how the therapeutic relationship would evolve", suggesting to Michael that at some point he might experience an erotic transference towards her. He went on to note that perhaps it might be even more difficult if a male therapist suggested this to a female client.

M 257: I don't know if it's easier for a female to say that to a male, but I think.. I don't know whether it would seem like arrogance from a male, to say to a woman.

As the interview progressed, Michael reflected on how he would feel in this situation.

M 265: I can imagine if it was me, emm, if I did have a transference with a female therapist, and for it to be named, I would absolutely feel

completely humiliated. That would be my sense of it.

The researcher's sense here is that once again, the therapist was hiding his own anxiety behind the idea of a boundary that was supposedly in place to protect the client. It took some probing from the researcher to get to the actual issue.

Amy had recently received a gift from a client, which was a painting that the client had bought. Receiving this gift caused "massive anxiety" for Amy. While she had received boxes of chocolates at Christmas from other clients, she had a sense that this gift had "something else behind it that is pushing the boundaries".

A 227: Because it's more than giving a gift, I think it's more than saying thank you or I'm grateful for this, I think it's a power dynamic I think as well.

As the researcher and Amy explored this issue further, Amy talked about not wanting the painting in her home, not wanting her children to ask where it came from (more on this in the theme "Contamination" in Section 4.4). Eventually, Amy talked about a sense of intimidation she felt with this client.

A 242: I've been seeing her on and off for a year and a half, two years. And she would be in a profession not unsimilar to this. And there would be some kind of blurring of the, you know, are we friends or are we, are we colleagues, and I think on another level as well, she triggers something within me about my own family. So I do find it quite difficult to navigate through this, and put a boundary down, because I think on some level, I'm quite intimidated by her.

The researcher got a sense here of layers needing to be peeled away, to get to the core issue. For Amy, this feeling of intimidation seemed to be hidden away under a boundary she was placing between her work-life and her home-life, to protect her children.

With each of the participants then, an initial reason was given for putting a boundary in place, and this tended to be related to protecting the client, or to advice received during training. However, with further questioning, a deeper reason emerged for the boundary, which was about avoiding uncomfortable feelings. The uncomfortable feelings, along with the desire to avoid them, were hidden behind the word “boundary”.

4.4 Contamination

The previous theme indicated that participants were using the idea of boundaries to avoid uncomfortable feelings. To defend against these feelings, the participants created boundaries, which were ostensibly for the benefit of the clients.

One type of boundary that emerged during the interviews was the boundary between work-life and personal-life. Related to this boundary was the idea of the therapist’s home-life being contaminated by the therapeutic work.

Returning to Frances’ phone-call with a client during a Christmas break:

F 38: We were going to have a break for Christmas, for two weeks, and the client mentioned in the session that she might find that difficult. I’d been working with her for over a year, and I understood that. So I said that it would be ok, if she needed to talk, that perhaps if she sent me a text, that I would respond, probably not immediately, but within two or three or four hours.

The client got in touch with Frances by text message, and Frances had a “very boundaried phone call for 15 minutes with her”. Following this phone call, they resumed their sessions as normal, “it was very contained”. Frances took this call in her home-office.

F 51: Well I stood in my office. I have a room at home. . . I wouldn't be in the kitchen now, I wouldn't have been in my family room, I was in the office upstairs for that call at that time.

The researcher got a sense here that Frances was trying to prevent the therapeutic work from contaminating her personal-life, by setting rules around the phone-call, and by avoiding having the phone-call in a family-room.

F 63: I need to do that for my own... I have two teenagers and a husband and a lot of friends, and I really keep my work as separate in that way. Cos it contains it for me too.

Frances also spoke about working in a centre for survivors of sexual-assault, as a pre-accredited therapist.

F 110: So if we're talking about boundaries, what I think really helped me was, as difficult as the material was that I was hearing, I could be present with my client, knowing that I had peer-support from a supervisor very quickly afterwards. It was available to me, before I left the building . . . I don't think I could have done the work without knowing what's the boundary for me personally, I've got to meet my husband for a drink tonight, and you don't want to carry this piece.

Once again, there is a fear of this difficult work contaminating the therapist's personal-life. Having supervision in the centre meant that Frances could meet her husband, and not have their date contaminated by material from the sessions. Frances also spoke about having separate clothes for work, and there appeared to be something about changing clothes that meant that she could separate work-life and personal-life, thereby preventing any contamination of her personal-life.

F 129: And bearing in mind, I have my own boundaries around wearing certain clothes for work. And I have certain clothes for home. . . It helps that when you're not wearing those clothes, you're fresher to do

other things in your personal-life.

Amy's example with the painting demonstrated a strong defence against her therapist role contaminating her personal-life.

A 233: And it's not on my wall, it's packed away, because I don't.. No.. I couldn't. . . Every time I would see it I would think of that client, and I would think of my work-life, and that's, that's my home, that's.. I don't want to be thinking about work when I'm there. Like, I actively just don't want to be thinking about work. I want to be boundaried about it.

Amy talked about having two small children, and about not wanting them to pick up on the disturbing material she encountered in the therapy room.

A 272: And you know how this, all these emotions kind of seep, from one person to another. And I've two little kids, you know, I want them to feel that, that love and inspiration and human spirit, but I don't want them to feel that pain or psychosis or suicidal thought, you know, I don't want to bring that into my house.

For Amy, some of this fear appeared to result from her work with a client with psychosis, during the early stages of her training. She had tried working with this client in a humanistic way, and described it as a "terrifying experience". Amy mentioned again how "that can really seep into you". Amy had previously had this experience of feeling contaminated by client work, and was trying to avoid this from recurring by placing a boundary between her work-life and personal-life.

Amy's story of "loosening the boundary" by giving a client her personal phone number also suggested something of contamination. Amy noted that during that time, "I really did feel it in my life". It was as though something of the therapy work had contaminated her personal-life while the client had her personal number.

Michael talked about occasions when the fantasy of a client's relationship had contaminated his own personal relationship.

M 278: I suppose there are times, like, when clients are talking about their romantic relationships, and you know, they could be really really strong and positive, and I suppose there could be an envy there as well at times . . . I think there has been times where I've resented my partner for not being the fantasy that maybe the clients are bringing in about their relationships.

The researcher had a sense that Michael had created less of a boundary between his work-life and his personal-life. Michael used the word "boundary" less than the other two participants, and spoke about character traits that he tried to bring to all his roles in life. In this sense, he appeared to create less of a division between his roles, and he didn't talk about switching in and out of therapy-mode.

Michael went on to say that he probably didn't always give his loved ones the same level of attention that he gave his clients. He was the most open with his own personal struggles, and was the one who appeared to be defending least against contamination of his personal-life. While Michael recognised that at times he resented his partner for not living up to the fantasy of some clients, Michael also seemed to have worked through this. It was not presented so much as a live issue, but more as something that he had recognised and worked on. Michael also stayed on chatting with the researcher for almost thirty minutes after the interview had ended. The researcher sensed a fluidity in Michael's boundaries; he appeared to experience less need to rigidly separate different areas of his life.

With all three interviewees, there was a sense of the work contaminating the therapist's personal-life. The participants all had experience of their personal-lives being impacted by the therapeutic work. Each participant had taken a different

approach in response to this. One participant had put rules and rituals in place to prevent contamination, another participant actively avoided thinking about work while at home, and the last participant appeared to accept the inevitability of his personal-life being affected by his work as a therapist.

Chapter 5: Discussion

5.1 Introduction

This research aimed to investigate psychotherapists' experience of developing boundaries in therapeutic work. The main objective of the study was to explore the experience of pre-accredited or recently accredited psychotherapists, as they developed boundaries in their work. To this end, a qualitative approach was chosen, using Interpretative Phenomenological Analysis to gain a rich understanding of the lived-experiences of these psychotherapists, and into how they made sense of their experiences.

The study produced three themes, which were identified and explored in Chapter 4. The current chapter reviews the existing literature on boundaries in psychotherapy, and compares it to the findings of this study. The findings are discussed under each of the three themes, and linked to the relevant literature as outlined in Chapter 2.

5.2 Boundary: A Blanket Term

The findings from this research study show that the word "boundary" was used to describe multiple phenomena. Reviewing the data, it is challenging to arrive at an over-arching sense of what a boundary is. Gutheil & Gabbard (1993) acknowledge this difficulty in defining a boundary, drawing a parallel to a phrase attributed to St. Augustine about time: "Time? I know what time is, provided you do not ask me" (p. 189). Barratt (2015) similarly notes that although the presence of a boundary can often seem obvious, the boundary itself tends to defy definition.

A boundary can be defined as a dividing, or as the limit of an activity ('boundary - definition of boundary in English | Oxford Dictionaries', n.d.). The latter definition fits with a definition of a boundary as being the limit of appropriate behaviour (Gutheil & Gabbard, 1998)

In this research study, the meanings attributed to the word "boundary" were divided into six categories:

1. Boundaries were used to describe how communications took place with clients, outside the therapy room.
2. Boundaries were used to describe the holding and containment of a therapy session.
3. Boundaries were described around disclosing personal information to clients.
4. Boundaries were described as foundational to human relationships, and particular boundaries were identified around the therapeutic relationship.
5. Boundaries were used to describe a demarcation line between work-life and personal-life.
6. Boundaries were used to describe the management of the practical aspects of the therapeutic relationship, notably the fees, timing and cancellation policy.

This research paper does not explore each of these categories in depth, but rather gives a sense of the breath of these categories, and the implications for having so many meanings attributed to something considered fundamental to the work of psychotherapy.

Comparing this list to the dictionary definition, both types of boundaries are evident. Participants spoke about a boundary being a dividing line when they attempted to separate work-life from personal-life. If one imagines a boundary being created around the therapy room, then this type of boundary fits in with the idea of a holding-environment where the client feels safe (Winnicott, 1960). Boundaries were expressed as the limit of acceptable behaviour when participants spoke about how they communicate with clients outside sessions, about disclosing personal information and the inappropriateness of a sexual relationship with a client.

The idea of a boundary as the limit of appropriate behaviour fits well with Michael's description of using boundaries when dealing with erotic transference. While Michael acknowledged feeling an attraction to clients, he also maintained an awareness that therapeutic boundaries are "absolutes", and that acting on his attraction would be beyond the limit of appropriate behaviour.

Behind these categories of boundary was the sense that boundaries are central to human relationships, and to the work of a psychotherapist. Amy noted the "massive impact" in the lives of clients, when they began to build up their personal boundaries. This ties in with the literature, which suggests that boundaries are at the core of human relationships (Whitfield, 1993). As the client-therapist relationship is central to psychotherapy, it would therefore make sense that boundaries are a core element of psychotherapy (Whiston & Sexton, 1993; Clarkson, 2003).

Another factor that has brought boundaries into the spotlight in psychotherapy is the fear of accusation of malpractice and sexual misconduct (Gutheil & Gabbard, 1998). A review of the literature shows that much of the writing on boundaries is associated with ethical issues or boundary violations, with titles including as "Interpersonal

Boundaries: Variations and Violations”, “Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers?”, “The gray areas of boundary crossings and violations” and “To Cross or Not to Cross: Do boundaries in therapy protect or harm?” (Glass, 2003; Zur, 2004; Akhtar, 2006; Audet, 2011).

Barratt (2015) notes that while there is a significant volume of literature regarding the consequences of boundary violations, there is much less writing on the definition of boundaries. There appear then to be two driving forces for the importance of boundaries: the first being that boundaries are central to human relationships, and the second being the concern around litigation, should a boundary violation take place. All the participants spoke about there being an emphasis on boundaries in their training, and all participants described themselves as “boundaried”. Yet, despite this emphasis on the importance of boundaries, there was a lack of clarity on the nature of boundaries.

Gutheil & Gabbard (1998) differentiate between external boundaries and psychological boundaries. They suggest that external boundaries are put in place to allow psychological boundaries to be crossed, via the mechanisms of psychotherapy, such as projection, transference and empathy. By creating a safe space and framework in which the work takes place, the therapist is enabling a deeper level of interpersonal communication.

In this research study, participants did not explicitly refer to boundaries as being external or psychological, and some of the boundaries discussed do not fit neatly into either category. Frances created an external boundary by choosing to rent a therapy room, rather than practice therapy in her home-office. However, she also appears to have created an internal psychological boundary by attempting not to

allow her work impact her family life, which manifested itself in her “boundaried” phone-call. Similarly, Amy created an internal psychological boundary, talking about actively not wanting to think about therapy when she is not in the therapy room.

Smith & Fitzpatrick (1995, p. 499) define therapeutic boundaries as a frame which describes roles for the participants in the process. They categorise the elements within this frame as being structural and content related. This division is also evident in how the participants spoke of boundaries. Frances’ phone call with a client during the Christmas break had boundaries both on structure and content. Structurally, the timing and duration of the call were agreed upfront, and Frances went to her home-office to make the call. She described the content of the call as also being “boundaried”, which meant that client issues were not opened-up, and that a clear next step was set to resume therapy at the next face-to-face session.

The literature thus shows many ways to categorise boundaries. Ken Wilber (2001) maintains that boundaries are items which exist only in human imagination, which suggests that boundaries are entirely subjective. This being the case, a boundary must be experienced to be understood; no amount of literature can convey the experience of a boundary. This fits with the assertion of Barratt (2015), that mental health professionals can generally agree that boundaries are necessary, but usually struggle to say where these boundaries should be placed.

Overall, the study findings correlate with the literature, which emphasises the importance of boundaries, but fails to define what a boundary is, or give a sense of the essence of boundaries. The focus on boundaries in the literature ties in with the emphasis placed on boundaries in training, which in turn fits with all the participants referring to themselves as “boundaried”.

On the one hand, both the participants and the literature emphasised the importance of boundaries. On the other hand, neither the participants nor the literature offered a single definition for a boundary, and as the next section shows, this resulted in experiences and feelings being hidden behind the word “boundary”.

5.3 What Lies Beneath: Hidden Behind Boundaries

The research study showed a lack of clarity on behalf of the participants, about who the boundaries were intended to benefit. Participants referred to boundaries that they had put in place to benefit their clients, but on further scrutiny, it became apparent that the boundaries were for the benefit of the therapists themselves. The study also identified a tendency for participants to justify these boundaries by saying that their training had emphasised the importance of boundaries.

Frances spoke about an encounter with a client outside of the therapy room, and about her concern that the client’s process would be disrupted. However, further discussion revealed Frances’ own discomfort at being seen while engaging in family-life. Frances rationalised this boundary-issue, by saying that her training had emphasised the importance of boundaries, and that she was “boundaried” in her work.

Dineen (2002, p. 119) claims that while it is often argued that boundaries exist to protect clients, the real reason for their existence is to preserve the power and status of the profession of psychotherapy. There are comparable findings in this research study, when boundaries were claimed to exist to protect the client, but on further investigation, turned out to be protecting the therapist.

Beneath the boundary there appeared to be something that the participants did not want to address, that they were able to avoid by saying that they were putting a boundary in place to protect the client. Based on the interviews, there are two levels of avoidance at work. Firstly, there is an uncomfortable feeling that is being avoided, and secondly there is the lack of willingness to admit to the presence of the uncomfortable feeling.

Each of these levels could be described as a defence mechanism. Anna Freud (1936/1993) described defence mechanisms as those unconscious methods used by the ego to avoid feelings of anxiety and displeasure. For Frances, the idea of being seen by a client while with her daughter and not dressed for work brought up a feeling of anxiety at being exposed. For Amy, there was a feeling of intimidation associated with the client who bought her the painting. For Michael, there was embarrassment at the thought of naming an erotic transference, when a client appeared to be experiencing attraction to him. Each participant was feeling discomfort, and appeared to be using the notion of a boundary to avoid this feeling of discomfort. By stating that they were “boundaried” in their work, they could compartmentalise these uncomfortable feelings and continue the work. Dineen (2002) suggests that it is in the nature of boundaries that they can be built, removed or changed at any time (p. 119). Wilber (2001) maintains that boundaries exist only in the human mind, and serve to separate something which is outside from something which is inside. Thus, the participants could build boundaries to avoid these unpleasant feelings.

However, there was also the second level of avoidance. Not only were the participants using the idea of a boundary to avoid the uncomfortable feeling, but

each participant initially said that they were doing this for the benefit of the client. Frances was “boundaried” about meeting clients outside the therapy room, so as not to disrupt the client’s process. Amy perceived that the client with the painting was playing out a power dynamic, and said she would be doing the client a disservice by not addressing this. Michael said that he thought it would be uncomfortable for the client to have the erotic transference named, and therefore did not address the transference directly. By making this issue about the client rather than the therapist, it appears that a further feeling was being avoided. This fits with the tendency of defence mechanisms to restrict or distort a person’s perception of an uncomfortable reality (Adams & Riggs, 2008, p. 27).

Each of the participants appeared to be experiencing shame about their uncomfortable feelings. Norcross (2000) notes that a sense of shame can mean that psychotherapists are likely to over-personalise their uncomfortable feelings, whereas, the reality is, these feelings are common to workers in the field of psychotherapy. One of the author’s recommendations to psychotherapists is to recognise that the profession is demanding and draining, and that stress is a natural response. As Sigmund Freud (1905/2001) stated, “No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed” (p. 109).

Zerubavel & Wright (2012, p. 488) wrote that the profession of psychotherapy has tended to silence or reject the idea of the therapist as a wounded healer. This argument correlates with the findings of this study, with the participants seeming quite uncomfortable in sharing their woundedness. All the participants tended to

name boundaries as being for the benefit of the clients, rather than speaking about their own anxieties.

To recognise and work with resistances and defence mechanisms, it is important that psychotherapists attend personal psychotherapy and supervision (Neumann & Gamble, 1995; Adams & Riggs, 2008). However, there is also an onus on the profession of psychotherapy to be more accepting of therapists' difficult experiences and feelings. If the profession sees anxiety as a weakness, then psychotherapists are less likely to present their anxiety to supervisors.

In summary, each participant in the study was experiencing uncomfortable feelings, most notably anxiety, intimidation and embarrassment. The literature states that this is to be expected when working in a caring profession such as psychotherapy. Rather than name and own these feelings, the participants tended to repress them. This action links in with the literature on shame in the profession of psychotherapy. By creating boundaries which were named as benefitting the client, the participants were also able to avoid this sense of shame. Consequently, the participants were bringing their own resistances into the therapeutic relationship, both about their anxieties and their shame. This fits with Lacan's (1978/1991) assertion that the only resistance is "that of the analyst" (p. 228).

5.4 Contamination

The third theme to emerge from the research study was contamination. This theme relates to the boundary between work-life and personal-life. All participants gave examples of times when their personal-lives were impacted by their work as a

psychotherapist. The words “contaminate” and “seep” were used to describe this impact.

Amy believed her boundary was pushed when she received a gift of a painting from a client, and was not comfortable displaying this painting in her home. The painting would remind her of the client, which would remind her of her work, and she did not want this reminder in her home. For Amy, this was a source of considerable anxiety, and Amy appeared to have quite a rigid boundary between her work-life and her personal-life. Frances took a “boundaried” phone-call from a client over the Christmas break, from her home-office. By placing a boundary around the phone-call, Frances appeared to be protecting her personal-life from contamination. Frances had found techniques which helped her to separate her work and personal-life, such as changing her clothes and using a home-office, and seemed to experience less anxiety about contamination. Michael said that the fantasy of his clients’ relationships had contaminated his relationship with his partner, in that he sometimes felt envious of this fantasy, and resentful of his partner. For Michael, this appeared to be a natural consequence of working as a therapist, and rather than taking steps to prevent this from happening, Michael seemed to have recognised this phenomenon and worked with it.

In speaking about contamination, Frances and Amy appear to be referring to countertransference, compassion-fatigue and vicarious trauma. In Sigmund Freud’s view, countertransference was a result of the influence of the patient on the unconscious feelings of the analyst (1910/2001, pp. 144–145). This was enabled because of unresolved conflicts in the analyst, and could and should be addressed through self-analysis.

This definition of countertransference fits with Amy's description of the client who gave her the painting. After some exploration, Amy recognised that she felt threatened by the client, who worked in a similar profession to Amy. Amy may have been experiencing a countertransference, where she had unresolved feelings of insecurity, which were triggered by her interactions with this client. These feelings were initially unconscious, and Amy reacted by putting a defence mechanism in place in the form of a boundary.

However, this study shows phenomena that operate differently to Freud's countertransference. The participants had an anxiety about their lives being contaminated by what they experienced in the therapy room. Frances and Amy were both concerned about the impact on them if their psychotherapy work were to enter family homes. Figley (2002) describes compassion-fatigue as a "secondary traumatic stress reaction", which results from helping a person who is suffering (p. 1435). Compassion-fatigue results in preoccupation and tension for the care-giver. Compassion-fatigue is a form of vicarious traumatisation, where the care-giver experiences disruption as a result of the trauma experienced by the client (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). While countertransference is more to do with the therapist's family-of-origin, compassion-fatigue is more to do with the trauma of the client. Figley (2002) cites the ability to disengage as one of the key factors in reducing compassion-fatigue. Disengaging requires active recognition of the need to let go of sensations, feelings and thoughts associated with the client. All participants in this research study identified ways of disengaging. Amy put a psychological boundary in place, by actively not wanting to think about clients at home. Frances had structural boundaries; changing out of her work-clothes and

using a home-office. Michael spoke about using mindful physical training to disengage from client-work.

Amy did have previous experience of her work having a deep impact on her. She talked about working with a psychotic client in her early days as a trainee psychotherapist. She began by trying to work humanistically with this client, attempting to empathise with the client's experience. Amy described this experience as terrifying, and noted how this experience can "seep into you". Figley (2002) argues that there is an emotional cost to being empathic. By entering the world of someone who is suffering, the care-giver also suffers. With Frances and Amy, there appeared to be a fear of experiencing vicarious trauma, of bringing the client's trauma into the therapist's personal-life. The literature suggests that those newest to the work are most likely to experience difficulty with vicarious trauma (Pearlman & Mac Ian, 1995). Figley (2002) argues that a psychotherapist must experience the suffering associated with empathy, in order to put safe-guards in place to mitigate against this suffering. Having suffered while working with the client with psychosis, Amy had created strategies to disengage from clinical work.

Norcross & Guy (2007) note that psychotherapists working with people suffering from acute psychopathology may particularly struggle to leave their work behind when they go home (p. 107). The authors suggest that in these cases, it is unrealistic for a therapist to hope to leave the work in the therapy room. They note the importance of a therapist having a vibrant, fulfilling life outside of their work with clients. This could involve other professional work in the field, such as supervision teaching or writing, or pursuing unrelated activities. This fits with Frances' statement that she has a "very varied happy personal-life outside my work as a therapist".

The literature suggests that it is important for psychotherapists to create boundaries between work-life and personal-life (Neumann & Gamble, 1995; Norcross & Guy, 2007). Rituals are recommended to mark the line between work-life and personal-life, such as meditation, a prayer, a change of clothes or some exercise. In the current research, Frances' ritual was to change out of her work-clothes, while Michael's ritual was physical exercise.

Norcross & Guy (2007) note that it would be easy for the role of psychotherapist to consume the therapist. When Amy loosened her boundaries, and gave her personal phone number to a suicidal client, she felt this impacted on her personal-life, noting that "I really did feel it in my life". Amy had a strong urge to prevent this from happening in the future.

Guy (2000) notes that spending time with troubled clients can take a toll after years of practice of psychotherapy. The author suggests that mirroring, or being admired by others, is an important remedy to this strain. If therapists do not find adequate mirroring among family and friends, they can turn to their clients for this mirroring. There is a value therefore in a healthy and supportive network, including a psychotherapist and supervisor, who can provide this mirroring for a therapist. In this research, all three participants spoke about loving relationships with their partners and children. All participants referred to their supervisors as a way to work through issues with clients.

It is note-worthy that the research study did not find consistent language or strategies among the participants for maintaining the boundary between work and personal-life, or for disengaging from client-work. Nobody explicitly spoke about the emotional cost of empathy. One participant had clear and quite rigid boundaries,

such as the home-office and the use of work-clothes. Another participant experienced anxiety when given a gift by a client; there was a link here between contamination and fear. The third participant did not name any boundaries between work and personal-life, but appeared comfortable with naming and working through such issues.

Perhaps with a greater understanding of countertransference, compassion-fatigue and vicarious trauma, participants could be more strategic with their self-care. By understanding the emotional cost of empathy, and the importance of disengaging, therapists could place firm but flexible boundaries between their professional and personal-lives, and focus on building a healthier balance between the two.

Chapter 6: Conclusion

The aim of this study was to explore psychotherapists' experience of developing boundaries in their work. The literature had shown that boundaries are central to the work of psychotherapy, while at the same time suggesting that due to their subjective nature, boundaries are difficult to define and describe.

This study found that participants concurred with the literature on the importance of boundaries in psychotherapeutic work. However, the word "boundary" was used so broadly by participants that the meaning of the word was lost. The emphasis on the importance of boundaries, combined with the lack of clarity on the nature of boundaries, meant that participants tended to fall back on a belief that they were "boundaried" in their work, instead of investigating what this meant.

In many cases, boundaries which were intended to support the client were often defence mechanisms within the therapist. The emphasis on boundaries in training was used to defend boundaries which were sometimes unhelpful in the therapeutic work. Anxiety was evident among the participants, but there appeared to be a feeling of shame about this, and rather than deal with the anxiety and shame, these were hidden behind the word "boundary".

Finally, the participants found that their personal-lives were impacted by their work as psychotherapists. They experienced this as a contamination of their personal-lives, and each participant had different methods of dealing with this phenomenon. The idea of contamination fits with the literature on countertransference, vicarious trauma and compassion-fatigue, which are understood to be common among psychotherapists, and particularly among less experienced psychotherapists.

However, there was no common language or strategy among the participants about how to mitigate against contamination in their lives.

6.1 Strengths

This in-depth exploration of the lived-experience of psychotherapists offers rich evidence of how boundaries are understood and experienced in psychotherapeutic work. The choice of Interpretative Phenomenological Analysis fits well with the subjective, nuanced nature of boundaries in psychotherapy. This exploration addresses a gap in current research, by exploring the nature and lived-experience of boundaries. It also makes a strong argument for training institutes to review how boundaries are understood by trainees. The homogenous grouping of participants who are trained in the humanistic-integrative modality, and who are pre-accredited or recently accredited, adds to the weight of the argument for this grouping.

6.2 Limitations

While the research produced rich findings, the small sample size and the subjective nature of the findings mean that it is not possible to generalise the results to the broad population of psychotherapists. Also, while all participants were either pre-accredited or recently accredited, there was significant variance in the number of client hours each had worked; this ranged from 360 to 1000 hours. Had there been more homogeneity in the hours worked, then the findings would better capture a snapshot at a given point-in-time in a psychotherapist's career.

6.3 Suggestions for Further Research

This study points to the need for further research into the nature of boundaries in psychotherapy. The word “boundary” appears to be overused in a way that is unhelpful for clinical practice. Further research into the broad use of the word “boundary” could help to develop a more useful nomenclature for the phenomena currently understood as boundaries.

Further research on the impact of the work on psychotherapists would also be helpful. This research could help to normalise the feelings of anxiety and stress experienced by psychotherapists, and therefore reduce the sense of shame experienced by these wounded healers. This, in turn, would mean that psychotherapists would not need to create boundaries to keep themselves safe from these uncomfortable feelings, and could instead maintain a curiosity about these feelings.

Hindsight is a wonderful guide. Were the researcher beginning again, the interviews would focus more on how the participants define the word “boundary”, and on the specific strategies used by participants to mitigate against contamination from their work-lives to their personal-lives.

6.4 Implications for Psychotherapy Practice

This research study has three main implications for psychotherapy practice.

The first is to encourage a review of the language used around boundaries in psychotherapy training. Boundaries are emphasised as important during training, but alongside this emphasis is a lack of clarity on the nature of boundaries. By exploring

different categories of boundary, and investigating the nature of these boundaries, trainee psychotherapists may find themselves better able to recognise when their own defence mechanisms are coming into the work. By recognising these defence mechanisms, psychotherapists would then have a choice about how to work with these, rather than having them inhibit the work.

The second implication for psychotherapy practice is for there to be more openness among psychotherapists around anxiety. Psychotherapists are human and are wounded, and therefore experience anxiety in their work. By denying this anxiety, psychotherapists are more likely to experience shame, and to attempt to hide this shame behind a boundary. It is only by owning this anxiety that psychotherapists can let go of boundaries which are unhelpful in the therapeutic relationship. It is important that trainee and qualified psychotherapists continue to focus on their own personal process, through psychotherapy and supervision, so they can recognise defence mechanisms and uncomfortable feelings, and work through these appropriately.

The final implication is for psychotherapists to have a greater awareness of the potential for disruption or contamination in their own lives. This would involve bringing countertransference, compassion-fatigue and vicarious trauma to the fore in training programmes, as well as focusing on methods for psychotherapists to disengage from clinical work. Trainee psychotherapists would then be more likely to effectively manage their wellness in the long-term, and less likely to experience anxiety about contamination.

References

- Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology, 2*(1), 26–34.
- Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, Exploration, and Separation: Illustrated by the Behavior of One-Year-Olds in a Strange Situation. *Child Development, 41*(1), 49–67.
- Akhtar, S. (Ed.). (2006). *Interpersonal Boundaries: Variations and Violations*. Lanham, Md: Jason Aronson, Inc.
- Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly, 24*(2), 85–100.
- Barratt, B. B. (2015). Boundaries and intimacies: Ethics and the (re)performance of ‘The Law’ in psychoanalysis. *International Forum of Psychoanalysis, 24*(4), 204.
- Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery, 34*, 239–244.
- boundary - definition of boundary in English | Oxford Dictionaries. (n.d.). Retrieved 5 June 2017, from <https://en.oxforddictionaries.com/definition/boundary>
- Bowlby, J. (1958). The Nature of the Child’s Tie to his Mother. *International Journal of Psycho-Analysis, 39*, 350–373.

- Bridges, N. A. (1999). Psychodynamic Perspective on Therapeutic Boundaries. *The Journal of Psychotherapy Practice and Research*, 8(4), 292–300.
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, 21(1), 87–108.
- Casement, P. (2013). *Further learning from the patient*. Hove: Routledge.
- Clarkson, P. (2003). *The therapeutic relationship*. London: Whurr.
- Dineen, T. (2002). The psychotherapist and the quest for power. In O. Z. Arnold A. Lazarus (Ed.), *Dual relationships and psychotherapy* (pp. 115–139). Springer Publishing Company.
- Fay, A. (2002). The case against boundaries in psychotherapy. In O. Z. Arnold A. Lazarus (Ed.), *Dual relationships and psychotherapy* (pp. 146–166). Springer Publishing Company.
- Figley, C. R. (2002). Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care. *Journal of Clinical Psychology*, 58(11), 1433–1441.
- Freud, A. (1993). *The ego and the mechanisms of defence* (Revised ed). London: Karnac Books. (Original work published 1936)
- Freud, S. (2001). *Volume 7 - A case of hysteria, three essays on sexuality and other works*. (J. Strachey, Ed.). London: Vintage. (Original work published 1905)
- Freud, S. (2001). *Volume 11 - Five lectures on psycho-analysis, Leonardo Da Vinci and other works*. (J. Strachey, Ed.). London: Vintage. (Original work published 1910)

- Freud, S. (2001). *Volume 12 - Case history of Schreber, papers on technique and other works*. (J. Strachey, Ed.). London: Vintage. (Original work published 1911)
- Frost, R. (2012). *North of Boston*. Createspace. (Original work published 1914)
- Geist, R., A. (2008). Connectedness, Permeable Boundaries, and the Development of the Self: Therapeutic Implications. *International Journal of Psychoanalytic Self Psychology*, 3(2), 129–152.
- Gerhardt, S. (2004). *Why love matters: how affection shapes a baby's brain*. Hove: Routledge.
- Gibson, M. F. (2012). Opening Up: Therapist Self-Disclosure in Theory, Research, and Practice. *Clinical Social Work Journal*, 40(3), 287–296.
- Glass, L. L. (2003). The gray areas of boundary crossings and violations. *American Journal of Psychotherapy*, 57(4), 429–444.
- Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *The American Journal of Psychiatry*, 150(2), 188–196.
- Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *The American Journal of Psychiatry*, 155(3), 409–414.
- Guy, J. D. (2000). Self-care corner: Holding the holding environment together: Self-psychology and psychotherapist care. *Professional Psychology: Research and Practice*, 31(3), 351–352.

- Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30*, 63–77.
- IACP Code of Ethics and Practice for Counsellors / Psychotherapists. (n.d.). Retrieved 24 June 2017, from <http://www.irish-counselling.ie/iacp-code-of-ethics>
- IAHIP Code of Ethics for Psychotherapists. (2010). Retrieved 24 June 2017, from <http://iahip.org/code-of-ethics>
- Jacobs, M. (2010). *Psychodynamic counselling in action* (4th ed). London: Sage Publications.
- Kahn, M. (1997). *Between therapist and client: the new relationship* (Rev. ed). New York, NY: Henry Holt and Company, LLS.
- Kelly, A. E., & Rodriguez, R. R. (2007). Do therapists self-disclose more to clients with greater symptomatology? *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 470–475.
- Kvale, S. (2007). *Doing interviews*. London: Sage Publications.
- Lacan, J. (1991). *The seminar of Jacques Lacan Book 2: the ego in Freud's theory and in the technique of psychoanalysis 1954-1955*. (J.-A. Miller, Ed., S. Tomaselli, Trans.). London: W.W. Norton & Company. (Original work published 1978)
- Lott, D. A. (1999). Drawing Boundaries. *Psychology Today, 32*(3), 48.
- Mason, J. (2002). *Qualitative researching* (2nd ed). London: Sage Publications.
- McLeod, J. (2001). *Qualitative Research in Counselling and Psychotherapy*. London: Sage Publications.

- McLeod, J. (2014). *Doing research in counselling and psychotherapy* (3rd ed). London: Sage Publications.
- Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy: Theory, Research, Practice, Training*, 32(2), 341–347.
- Norcross, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice*, 31(6), 710–713.
- Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: a guide to psychotherapist self-care*. New York: Guilford Press.
- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26(6), 558–565.
- Petronio, S. (2002). *Boundaries of Privacy: Dialectics of Disclosure*. Albany: State University of New York Press.
- Pietkiewicz, I. J., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7–14.
- Pietkiewicz, I. J., & Włodarczyk, M. (2015). Crossing the Boundaries of Privacy in Accidental Encounters: Interpretative Phenomenological Analysis of Therapists' Experiences. *Clinical Psychology & Psychotherapy*, 22(6), 708.
- Piovano, B. (2008). The function of the analyst's boundaries in the psychoanalytic relationship. *International Forum of Psychoanalysis*, 17(2), 91–103.

- Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology, 64*(5), 638–652.
- Proctor, G. (2014). *Values and ethics in counselling and psychotherapy*. London: Sage Publications.
- Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: the effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*(1), 49.
- Schwartz, R. S., & Olds, J. (2002). A phenomenology of closeness and its application to sexual boundary violations: a framework for therapists in training. *American Journal of Psychotherapy, 56*(4), 480–493.
- Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice, 26*(5), 499–506.
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39–54.
- Smith, J. A., Flowers, P., & Larkin, M. H. (2009). *Interpretative phenomenological analysis: theory, method and research*. London: Sage Publications.
- Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 53–80). London: Sage Publications.

- Whiston, S. C., & Sexton, T. L. (1993). An overview of psychotherapy outcome research: Implications for practice. *Professional Psychology: Research and Practice*, 24(1), 43–51.
- Whitfield, C. L. (1993). *Boundaries and Relationships: Knowing, Protecting and Enjoying the Self*. Health Communications, Inc.
- Wilber, K. (2001). *No Boundary: Eastern and Western Approaches to Personal Growth* (New edition edition). Shambhala Publications Inc.
- Winnicott, D., W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psycho-Analysis*, 41, 585–595.
- Yardley, L. (2000). Dilemmas in Qualitative Health Research. *Psychology & Health*, 15(2), 215.
- Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy*, 49(4), 482–491.
- Zur, O. (2004). To Cross or Not to Cross: Do boundaries in therapy protect or harm. *The Psychotherapy Bulletin*, 39(3), 27–32.
- Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the Internet age. *Professional Psychology: Research and Practice*, 40(1), 22–30.

Appendices

Appendix 1: Participant Information Sheet

INFORMATION FORM

My name is Dermot Heslin and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project, which is concerned with the experience of pre-accredited or recently accredited psychotherapists in working with clients. I will be exploring the views of people like yourself, who are either recently accredited, or are working towards accreditation.

What is Involved?

You are invited to participate in this research because you have been identified as being suitable, being a psychotherapist who is either recently accredited, or working towards accreditation. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this time, I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information shared by you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a secure digital location. The key to the code numbers will be kept in a separate secured file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and, if it is used for future research, it will be handled in the same way. Audio recordings and transcripts will be made of the interview, but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

If you have questions regarding your rights as a participant in this research, please contact Dr. Gráinne Donohue, Research Co-ordinator, Dept. of Psychotherapy, School of Arts, Dublin Business School grainne.donohue@dbs.ie

Appendix 2: Consent Form

Research Title:

An investigation into therapists' experience of developing boundaries

Please tick the appropriate answer.

I confirm that I have read and understood the Information Form attached, and that I have had ample opportunity to ask questions, all of which have been satisfactorily answered. **Yes** **No**

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason. **Yes** **No**

I understand that my identity will remain confidential at all times. **Yes** **No**

I am aware of the potential risks of this research study. **Yes** **No**

I am aware that audio recordings will be made of sessions. **Yes** **No**

I have been given a copy of the Information Leaflet and this Consent Form for my records. **Yes** **No**

Participant _____
Signed and dated

Name in block capitals

To be completed by the Principal Investigator.

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study, in a manner that he/she could understand. We have discussed the risks involved, and have invited him/her to ask questions on any aspect of the study that concerned him/her.

Signature

Name in Block Capitals

Date

Appendix 3: Demographic Information Sheet

<p>Gender</p> <p><input type="checkbox"/> male</p> <p><input type="checkbox"/> female</p> <p><input type="checkbox"/> other (please specify) _____</p>
<p>Age-group</p> <p><input type="checkbox"/> 20-25</p> <p><input type="checkbox"/> 25-30</p> <p><input type="checkbox"/> 30-35</p> <p><input type="checkbox"/> 35-40</p> <p><input type="checkbox"/> 40-45</p> <p><input type="checkbox"/> 45-50</p> <p><input type="checkbox"/> 50-55</p> <p><input type="checkbox"/> 55-60</p> <p><input type="checkbox"/> 60-65</p> <p><input type="checkbox"/> 65+</p>
<p>How long have you been practicing as a psychotherapist, post-graduation?</p> <p>_____ years _____ months</p>
<p>Approximately how many client hours have you accumulated, post-graduation?</p> <p>_____ hours</p>
<p>Are you accredited as a psychotherapist?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>If yes, which body are you accredited with?</p> <p><input type="checkbox"/> IAHIP</p> <p><input type="checkbox"/> IACP</p> <p><input type="checkbox"/> Other (please specify) _____</p>
<p>What was the orientation of your core training?</p> <p><input type="checkbox"/> Humanistic and Integrative</p> <p><input type="checkbox"/> Psychodynamic</p> <p><input type="checkbox"/> Gestalt</p> <p><input type="checkbox"/> Other (please specify) _____</p>

Appendix 4: Guide Questions

1. Can you tell me what drew you to this work?
2. Looking back, how would you describe yourself at the outset of your clinical work?
3. What do boundaries mean to you in the work?
4. How do you manage boundaries with your clients (note if physical or other boundaries are mentioned)?
 - a. Follow-on: can you tell me about how you manage communications with clients by phone or email?
 - b. Follow-on: how do you manage fees, how does this manifest in the work?
 - c. Follow-on: have you dealt with any challenges regarding your cancellation policy?
 - d. Follow-on: can you talk about any issues with clients arriving late, or not showing?
5. Can you tell me about a time when you have been deeply affected by an encounter with a client? (specifics)
 - a. Follow-on: what do you think affected you so deeply?
 - b. Follow-on: what did you take away from this experience?
 - c. Follow-on: If the word “boundary” is used, ask about this. How does this relate to boundaries?
 - d. Follow-on: If the word “boundary” is not used, then bring this word in. Ask if there was something to learn in this about boundaries.
6. Can you tell me about experiences with clients that you have found challenging? (this will likely already be covered by previous question, so might go straight to follow-ons – push about boundaries vs transference)
 - a. Follow-on: talk about times when you felt a client was challenging you in your role as a psychotherapist.
 - b. Follow-on: talk about times when you may have pushed questions too far?
 - c. Follow-on: talk about any experiences of erotic transference?
7. Can you tell me about any occasions when you have disclosed personal information to clients?

- a. Follow-on: what was the impact of this on you / the client / the relationship?
 - b. Follow-on: Ask about what meaning the interviewee has taken from this? (boundaries / resistance)
8. How do you think your work as a psychotherapist has impacted on other areas of your life? (encourage specificity)
- a. Follow-on: how have your personal relationships changed during your time working as a psychotherapist?
9. Could you tell me how you have experienced this interview?
10. Is there anything else you would like to add?

Follow-up regarding the impact of the situation, the resultant change. Be ready to ask whether the interviewee is describing a boundary, transference, a resistance?

Appendix 5: Sample Analysis

Analysis from interview with Frances (researcher questions in bold).

Line	Original Transcript	Close Line by Line Analysis	Researcher Thoughts	Theme
1	So there was almost a boundary around the centre, in a way, in that you had your diary in the centre, you had your supervision there, there was something about walking out of that...	So there was a boundary around the centre – you kept your diary there, had supervision there?		
2	I was very held and contained, and that held and contained the work I was doing.	I was held and contained there, which held and contained my work.		
3	OK, wow.			
4	Very professional, I couldn't speak higher about it, and the experience, you know for me.	It was very professional. I would speak very highly of it.		
5	And bearing in mind, I have my own boundaries around wearing certain clothes for work. And I have certain clothes for home.	I have boundaries around certain clothes for work. And certain clothes for home.	Curious how she brought this in now.	Contamination
6	It's just something personal I do. So I have work-clothes for therapy work, and just for me that's a boundary around it too.	It is something personal I do. It's a boundary.	"that's a boundary around it too" – to do with clothes. Overuse of the word "boundary"?	Contamination Blanket Term
7	What's that doing? Is it a certain style? A certain presentation you're going for? Or is it just a set of clothes?	Tell me more		
8	It's more than just a style or how I want to look in my work, it's a sense of... it's a boundary, it's a piece of.. how would I say, it's a self-care piece that I have an association with certain clothes for work, and other clothes for when I'm not working. I'd see that as a boundary too. Yeah.	It's more than a style or how I want to look. It's a boundary, a self-care piece. I have an association with certain clothes for work, and for when I'm not in work. I see it as a boundary.	Sense of a real effort to build boundaries. To keep her safe from the work?	Contamination Blanket Term

	It helps.			
9	So there's something about, almost like, changing out of clothes, that's changing out of...	So, changing out of clothes, you're changing out of..		
10	Well they're still my clothes, do you know what I mean? And I choose, you know, it might just be a cardigan top and trousers, you know, similar type clothes for when I was working in the Rape Crisis Centre.	Still my clothes. Maybe just a cardigan top and trousers, similar to what I wore in the Rape Crisis centre.		
11	It helps that when you're not wearing those clothes, you're fresher to do other things in your personal-life.	When not wearing them, you're fresher to do things in your personal-life.	Second person. Shedding the work clothes.	Contamination
12	I have a very varied happy personal-life outside my work as a therapist.	I have a varied happy personal-life.	Needing to justify this?	
13	I don't want to sound like I'm disowning parts of me, and I'm not integrated as a therapist, but for that self-care, boundaries around very difficult material that I might be meeting, it does help. And I find that for myself.	Don't want to sound like I'm disowning parts of me, or that I'm not integrated. But for self-care, boundaries around difficult material do help.	Recognising (unprompted) what I have been picking up – something about non-integration. Need for boundaries to shield herself.	Contamination

