The Concept of 'Boundary' within the Field of Counselling

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Abstract

Rationale. The concept of 'boundary' is ingrained within the counselling literature and ethical frameworks and is often reported by counsellors as part of their experience of counselling. Yet the academic research base in the United Kingdom (UK) upon which the concept is based is limited, with much being derived from the American psychiatric and psychotherapy literature. There is an even greater absence of UK research which considers the concept of boundary from the counsellors' perspective.

Method. This thesis seeks to begin to address that gap in knowledge. It presents qualitative research which explores in depth how counsellors understand and experience the concept of boundary in their practice. Using a phenomenological approach, interviews were completed with seven qualified and practicing counsellors in the UK. These interviews are analysed using multiple qualitative methods. These methods produced their own methodological insights.

Findings. Six major findings are identified in the interviews: the participants had an idiosyncratic understanding of 'boundary' which means no single definition can be stated. Participants find it difficult to define boundaries but are easily able to articulate how they responded to 'boundary issues'. Participants have their own 'boundary attitude' that is their own unique general approach to boundaries which is mainly influenced by their own values and beliefs. This approach does not necessarily correlate with their modality's traditional view of boundaries. Participants' feelings of shame (or their apprehension of feeling shame) is a highly influential factor in how they respond to boundary issues. Participants respond to boundary issues with defensive practice when they experience feelings of shame or are fearful of experiencing shame. Participants use a thickening of boundaries to protect themselves from the threat of experiencing shame.

This thesis proposes two models based on the participants' understandings and experience of 'boundary'. The Boundary Process Map charts out the overall process of how participants experience boundary issues in their practice. The Boundary Response Model (BRM) identifies more specifically how participants respond to boundary issues. These models have influenced the creation of two sets of questions; Boundary Attitude Questions and Boundary Issue Questions which can be used by counsellors, supervisors and trainers to support counsellors in exploring their general attitude and understanding towards boundaries whilst also exploring their response to specific boundary issues.

Recommendations. This thesis is the first study to explore boundaries from the perspective of the counsellor. Therefore, this research offers valuable new insights into the concept whilst also identifying potential new areas of study. Furthermore, this research proposes new insights for training and practice of counsellors when working with boundary issues including terminological recommendations.

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I would like to thank the participants of this study who shared their knowledge and experiences for this study. Although I tried to make this process as easy and comfortable as I could for participants it is easy to forget that having your thoughts and feelings recorded, analysed and shared can be a daunting experience. It is also important to acknowledge that without them research such as this could not take place.

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Chapter One: Introduction

'Where do I draw the line?'

This thesis has its origins in the apparent confusion and misperception of the concept of 'boundary' in counselling practice. As a student counsellor I was taught about the importance of boundaries to my practice, but became increasingly frustrated at the lack of a satisfactory definition of the concept. Furthermore, the breadth of interpretation by tutors, fellow students and other counsellors of what are 'acceptable' boundaries in counselling practice has both surprised and intrigued me!

My own experience of the 'boundary' concept has greatly influenced my motivation in completing this piece of research which I think is important to acknowledge. I will reflect upon my role as researcher throughout this thesis and the impact that this has had on the research process. However, here I report the events which led to my initial interest in this topic.

I am a qualified person-centred counsellor and member of the British Association for Counselling anf Psychotherapy (BACP). I have worked with clients covering a multitude of issues from bereavement, alcohol abuse, phobias to relationship issues. I am also qualified as a Social Worker. In this role I have primarily completed work with children with disabilities, although my role has also encompassed child protection and safeguarding, mental capacity assessments and best interest processes. Both my professional roles and personal motivations have influenced the writing of this thesis and are reflected on throughout.

Throughout my counsellor training (and the writing of this thesis) I observed that the term 'boundary' was frequently used but often left unexplained by those using it. This included tutors on my training course and counsellors I have seen for personal therapy (which was required as part of my training). Fellow students often acted as if they

understood what was being referred to, however I began to feel that meanings were often ambiguous and the term used to cover a multitude of things, depending on the context of the discussion.

In addition to the term being used in a vague and unspecific manner, I also witnessed that individual attitudes towards boundaries quite often differed. The counselling literature often highlights different approaches to boundaries from different therapy traditions (Kent, 2013). However, I was identifying counsellors with similar theoretical backgrounds discussing boundaries in very different ways. It was the search for my own personal therapist, and my experiences during my counsellor training that also deepened my interest in the issue of boundaries.

My search for a counsellor with whom I felt able to work effectively was challenging. I approached three counsellors all of whom I found unhelpful. Similar to other therapists who have experienced 'unhelpful therapy' I identified the lack of negotiation in contracting, limited use of collaboration and a lack of care from the counsellor as major factors in influencing my negative experience (Bowie, McLeod and McLeod, 2016).

 In addition to my own personal therapy I was, at the time, listening to other students recount their stories of personal therapy and their experience of boundaries often appeared just as confusing as my own. This led me to question the boundaries of the counselling role, and how these are implemented and maintained by practitioners. If I was confused then surely clients with little or no knowledge of therapy would experience even greater confusion. Indeed, as Khele, Symons and Wheeler (2008) found, complaints against counsellors were more likely to come from other counsellors, or those associated with the profession. This may suggest that their additional knowledge of the field makes it easier to identify what should be expected

of a service, including the important issue of boundaries. However, it may also suggest that lay people have more difficulty in complaining.

The question then that these points raised for me is 'what are boundaries in counselling practice?' It was also the start of my interest into what other counsellors perceived to be 'boundaries' within their practice and how this relates to their professional values and ethics. Finally, it also made me question my own practice and ask the question – 'where do I draw the line?'

This thesis is a response to all those questions.

Defining Terms

This chapter explores the rationale for this thesis, outlines the aims of the thesis and then summarises its structure. In addition, it also specifies the remit of the thesis, detailing relevant assumptions and then frames that discussion within the context of counselling in the United Kingdom (UK) currently. Initially, however, it seems relevant to define the terms to be used. There are a multitude of terms used to refer to practitioners who work therapeutically with clients. These include, but are not restricted to – "counsellor", "psychotherapist", "psychotherapeutic counsellor" and "therapist". There is a longstanding view held by the British Association for Counselling and Psychotherapy (BACP) that it is not possible to make a general distinction between "counselling" and "psychotherapy" and their literature often reflects this with both terms being used interchangeably. Indeed, Bond (2015) reports that distinguishing between the two forms of therapy in the UK has been problematic. Certainly, this debate over terminology is not new with Feltham (1995) considering the arguments in full in his book - *What is Counselling?* Over twenty years ago he concluded that the differentiation between counselling and psychotherapy is 'pseudo-differentiation' (p163) and stated that he looked forward to a time when there is only one single

profession. Whilst it is beyond the realms of this thesis to consider these specific arguments in any detail, it is nevertheless important to acknowledge the debate and for clarity, specify how terms will be used here.

The terms "counsellor" and "therapist" will be used throughout this thesis interchangeably to refer to practitioners who deliver talking therapy. Any references to specific literature or research will use the original terms used in those sources. This thesis also draws upon some literature from outside of the UK and again any references to practitioners of talking therapies will use the original terms specified in those documents. Any potential issues that are raised when comparing these practitioners to UK counsellors and therapists will be highlighted as they are discussed.

The term 'therapeutic encounter' will be used to refer to the counselling process in its entirety. This term has been used, rather than say the 'therapeutic relationship', because it incorporates the holistic counselling experience including the client and the counsellor's perspective. It also includes the context within which the counselling sessions are held such as the organisational setting which may influence the therapeutic relationship but not necessarily be part of it.

As stated above, this thesis explores boundaries in counselling. A personal rationale for the study was given above. However, there is also an important academic rationale which is presented below.

Prominence of 'boundary' in counselling literature

Boundary is considered a key concept in counselling and psychotherapy (Smith, Collard, Nicholson and Bayne, 2012). It is used: in both introductory texts for counselling students (e.g. McLeod, 2013; Reeves, 2013) and handbooks for practice

(e.g. Feltham and Horton, 2012; Smith, Collard, Nicholson and Bayne, 2012); to underpin discussions in counselling ethics (e.g. Bond, 2008; Bond, 2015; Davies, 2015; Proctor, 2014); as a theme to group papers in counselling journals (e.g. Hartmann, 1997; Hermansson, 1997; Owen, 1997; Webb, 1997); in ethical codes (e.g. BACP, 2016a; COSCA, 2014; UKCP, 2009); in competency frameworks for counselling (e.g. BACP, 2016c; BACP, 2016d; Hill, Roth and Cooper, 2014) and counselling supervision (e.g. Roth and Pilling, 2015); in good practice guidance (e.g. Dale, 2016; Davies, 2015; Mitchels, 2016); in counselling magazine articles (e.g. Butler and McDonnell, 2012; Totton, 2010) - all of which has also spurned further debate from practitioners within the literature (e.g. Browne, 2010; Cobb, 2010; Devereux and Coe, 2010; Ingham, 2010; Priestly, 2010; Ryan, 2010; Solomon, 2010). Moreover, it is also used in literature that is available for counselling clients (e.g. BACP Register of Counsellors and Psychotherapists, 2016; Kent, 2013). Yet, curiously the concept itself is rarely defined. Rather, the word 'boundary' is used and there seems to be a general assumption that the reader or practitioner will know instinctively what is being referred to – and by implication, know instinctively when boundaries are being broken.

Lack of Definition

Over 25 years ago Gutheil and Gabbard (1993) noted that defining the term 'boundary' was a difficult and arduous task, being too abstract to clarify in one single definition. Current researchers appear to have not moved much further. Some current discussions centre on the 'ethical' or 'acceptable' behaviour of counsellors (Bond, 2015; Kent, 2013). However, many current researchers and authors leave the concept undefined (for example Ciclitira, Starr, Marzano, Brunswick and Costa, 2012; Feltham and Horton, 2012; Mitchels and Bond, 2010; Pope and Vasquez, 2016; Von Haenisch,

2011). **Therefore, the first aim of this thesis is to examine and explore the development of the concept of boundary within the field of counselling in the UK as well as identify the main discussion points within the literature.**

Counsellors' Perspective

Historically, the concept of boundaries was not explicitly defined by many of the traditional therapy founders (McLeod, 2003, p. 312) and certainly, different therapeutic traditions approach boundaries from different theoretical points of view (e.g. Jacobs, 2010; Mearns and Thorne, 2013; Süle, 2007) with many of the discussions surrounding boundaries in counselling happening at the theoretical level (for example Davies, 2007; Friedman, 2008; Gabbard, 2008; Goldberg, 2008a, b; Greenberg, 2008; Gutheil and Gabbard, 2003; Hermansson, 1997; Owen, 1997). Indeed, there are multiple boundary 'models' within the counselling and broader literature (for example Ashforth, Kreiner, and Fugate, 2000; Carey, 2016; Hartmann, 1997; Hartmann, 2011) which can be applied to counselling practice (for example Carey, 2016; Hartmann, 1997; Hartmann, 2011). This is unsurprising when it is considered that the boundary concept can be broadly viewed as a metaphor for counselling practice (Owen, 1997). However, these models are largely from a 'top down perspective. There is currently no model from the counsellor's perspective which represents how counsellors understand and experience and use boundaries within their practice. This is even more surprising when other professions have used the practitioner's experience of boundaries to inform their literature on boundaries (e.g. Doel, Allmark, Conway, Cowburn, Flynn, Nelson and Tod, 2009).

If one of the main aims of counselling research has been the "prevention and management of boundary concerns" (Webb, 1997, p. 175) then exploring the experience of boundaries from a counsellor's perspective would surely result in a

greater understanding in this area. There has been some research into therapists' experience of managing sexual boundaries in therapy (Martin, Godfrey, Meekums and Madill, 2011) and making therapeutic mistakes (Aaron, 2011). However, even in the narrow area of boundaries the literature is still sparse.

Associated fields have already started to explore the concept of boundary from the perspective of their practitioners (for example in Social Work see Doel, Allmark, Conway, Cowburn, Flynn, Nelson and Tod, 2009). Research has also explored the perceptions of practitioners of the boundaries between different helping professions such as coaching and counselling (Baker, 2014).

Despite this there is no research which examines specifically the issue of *how* counsellors understand and experience the boundary concept in their practice. If we gain a greater understanding of counsellors' experience of boundaries this can offer a greater insight into the dynamics of the therapeutic encounter. If their experiences are not considered, we are surely only looking at half the picture.

Arguably, the counsellor's understanding and experience of boundaries both in terms of their creation and maintenance, is central to the therapeutic encounter (McLeod, 2013). So, despite work focusing on the experiences of the client (e.g. Audet, 2011) since the clients experience is the primary concern of counsellors (BACP, 2016a); an awareness of the counsellor's perspective on the concept of boundary is surely very important. Further, given that client complaints are likely to be boundary related (Khele, Symons and Wheeler, 2008; Symons, Khele, Rodgers, Turner and Wheeler, 2011), it is argued here that it is just as important to investigate counsellors' knowledge, understanding and experience as they hold a pivotal role in creating and maintaining boundaries (BACP, 2015; Hartmann, 1997; Kent, 2013; McLeod, 2013;

Proctor, 2014; Owen, 1997; Webb, 1997). The lack of exploration of counsellors' understanding and experience of boundaries is perhaps even more surprising as the concept regularly appears as an important aspect of counsellor experience in counselling research studies (e.g. Aaron, 2011; Baker, 2012; Brown, 2006; Ciclitira, Starr, Marzano, Brunswick and Costa, 2012; King, 2011; Smith, 2016; Von Haenisch, 2011).

Therefore, the second aim of this thesis is to explore counsellors' understanding and experience of the boundary concept in their practice.

Stemming from the aims, the **<u>objectives</u>** for the study are as follows:

- **to produce a definition of 'boundary' from a counsellor's perspective**
- **to represent counsellor participants' understanding and experience of the concept of 'boundary'**
- **to compare counsellor participants' understanding and experience of boundaries with the current literature on boundaries**
- **to inform knowledge in this area (which includes counsellor and therapist training)**
- **to identify any potential new areas for future study**

<u>**Cultural shift.**</u>
Ten years ago Bird (2006) estimated that psychological therapies were being delivered by 100,000 practitioners in the UK. Arguably, this number has risen in the last decade. Yet, current membership of the British Association for Counselling and Psychotherapy (BACP) is approximately 42,000 (BACP, 2016c), with membership of the UK Council for Psychotherapy (UKCP) being approximately 7800 members (UKCP, 2016). This suggests that the majority of practitioners are not registered with either of these

professional bodies, which arguably are two of the major professional bodies for counselling and psychotherapy. Certainly, some will be registered with the British Psychological Society but also, many will likely be working without being registered to a professional body.

During the writing of this thesis the state of counselling in the UK is going through what could be considered a 'cultural shift'. Some have argued for a greater level of regulation for counsellors and therapists through protected titles and statutory intervention (Dore and Williamson, 2016). Research suggests that clients are overwhelmingly in favour of statutory regulation of counselling and psychotherapy services. For example, one survey found 85% of respondents agreed, with only 5% disagreeing (MIND, 2010). The profession has in some respects responded to such calls by creating a voluntary register for counsellors and psychotherapists who meet the agencies minimum standards (BACP Register of Counsellors & Psychotherapists, 2016). It is also endeavouring to build a profession that is based on research (e.g. Davies, 2015) and evidence based practice (BACP, 2013b). The advancement of randomised controlled trials (RTC's) as a measure of successful therapeutic outcomes seems unabated despite practitioners discomfort (Cooper & Reeves, 2012). The minimum standards for being a competent counsellor is coming to the fore more than ever before (Bond, 2015) evidenced further by the revision of the BACP Ethical Framework (BACP, 2016a).

Totton argued in 2010 that there was "a quietly ferocious struggle going on for the soul of psychotherapy and counselling" (para 1), which he said was evidenced in the push for further regulation and evidence based practice of therapists. Arguably, in 2016 this struggle is still ongoing as the profession appears to be approaching a post-modality era with the introduction of the pluralistic approach to counselling and therapy which

aims to move past the narrow focus of specific therapeutic traditions (e.g. Carey, 2016; Gabriel, 2016a).

It is in this context of a 'cultural shift' that this thesis is written.

It is therefore perhaps surprising that the concept of 'boundary' has had such limited exploration in research in contrast to its increase in use. Certainly, it has been critically examined to some level from a theoretical perspective (e.g. Feltham, 2010; Totton, 2010). However, within the (rightfully) heightened focus on research to support practice, it is curious to note the relatively scarce attention to 'boundary' and its impact on clinical practice. This thesis aims to begin to address this gap in knowledge and research.

Structure of the Thesis

This thesis is presented in eight chapters. Chapter one presents an introduction to the thesis. It highlights some points surrounding terminology, as well as outlining the parameters of this study. This first chapter also highlights common arguments surrounding the boundary concept in therapy, its rise in prominence within the literature and the aims and objectives of this thesis.

Chapter two is the *Literature Review*. This chapter expands on some of the literature outlined in chapter one. The initial section of the literature review considers the definition of 'boundary' as a pretext to exploring the discussion points in the literature. This chapter then reviews the current literature on boundaries by dividing it into five main discussion points. These are: (1) Boundaries and Counselling Ethics; (2) Exploitation and Abuse; (3) Boundary Issues; (4) Types of Boundaries (5) An alternative view of boundaries. Discussion point three examines the use of the term 'boundary issue' in the counselling literature (this was identified as a useful term which

is important for the arguments in this thesis). This section also provides a working definition of the term "boundary issue" to make discussion easier throughout the rest of this thesis.

Chapter three is the *Research Methodology*. This chapter reports the ontological and epistemological assumptions of the research and discusses my role in the development of the research methods, such as the development of the research questions and method of analysis. Researcher reflexivity is highlighted throughout this thesis; however it is discussed in the most detail within this chapter. The ethical considerations of this study are also included within this chapter.

Chapter four is the IPA findings. This chapter reports on the outcome of the IPA analysis. This chapter identifies the super-ordinate and sub-ordinate themes. The super-ordinate themes were (1) *Protection and Safety* and (2) The *Structure of Therapy.* A diagrammatical representation of the themes is given and a detailed exploration of the themes is presented with evidence from the interviews to support each theme. The link between the IPA analysis and the two models presented in the following two chapters is also presented.

Chapter five is the first model of this study and looks at the *Process of Boundary*. This chapter proposes and considers the first model created from the participants' understanding and experience of boundary. This is called the Boundary Process Map and is a representation of how the counsellor participants broadly approach boundary issues. New terminology is introduced and detailed for the explanation of this model and that informs further discussion in the rest of the thesis.

Chapter six is the second part of the findings of this study and looks at the *Boundary Response Model* (BRM). This chapter proposes a model of how counsellors' respond

to boundary issues that is based on the counsellor participants' experiences. This model proposes eight distinct responses to boundary issues which are described in this chapter with examples from the participant accounts. This chapter then further evidences the BRM by considering three detailed examples of boundary issues from the participants accounts and applying the BRM. The three boundary issues explored are (1) the discussion of the erotic in therapy; (2) charging a fee for counselling and (3) confidentiality.

Chapter seven is the *Discussion.* This chapter looks at the findings of this research and how this fits into the current counselling literature and practice. This chapter discusses practical applications of the proposed models and the need to validate them across a broader population of counsellors in the UK. This chapter also proposes two sets of questions to be used in conjunction with the two models which could help develop counsellors understanding and application of boundaries in their practice, as well as raise their awareness about how they respond to specific boundary issues. This chapter also proposes new areas of future research.

Chapter eight is the *Conclusion.* This chapter considers how the aims and objectives of this thesis have been achieved and how new insights were achieved which were not included in the original aims of this study. This chapter also includes a summary of recommendations for practice and future research. Finally, this chapter outlines and summarises this study's original contribution to knowledge and considers what is next.

Chapter Two: Literature Review

The first aim of this thesis is: **To examine and explore the development of the concept of boundary within the field of counselling in the UK as well as identify the main discussion points within the literature.**

So this chapter details the main discussion points of the concept of 'boundary' within the counselling literature whilst also identifying gaps within the research. First this chapter will outline some of the understandings and definitions of 'boundary' and consider its role within counselling in the UK. Following this a review of the literature will be presented around five main discussion points. These are: (1) Boundaries and Counselling Ethics; (2) Exploitation and Abuse; (3) Boundary Issues; (4) Types of Boundaries (5) An alternative view of boundaries?

Understanding and definitions 'boundary'

The first recorded use of the noun 'boundaries' (or 'bundaries') dates back to the 1620's (Harper, 2017). It is suggested to come from the Medieval Latin word bodina and may have been influenced by the word bonnarium meaning an area of land within a fixed limit (Harper, 2017). However, the word 'bound' dates back earlier than this to the 13th century, and means 'limit' from the Anglo-Latin word bunda (Harper, 2017).

Despite originating as a term to refer to geographical limits such as frontiers or the edge of farmland, it then began to be used to refer to other limits. In his book *Humane Understanding II*, Locke states that "The simple Ideas, we receive from sensation and reflection, are the boundaries of our thoughts" (Locke, 1801, p28). This quote is a very early example (the book originates back to the year 1690) of the term boundary being used to express theoretical limits rather than physical ones. It is also an early example of the term being used to describe psychological limits.

Contemporary definitions have varied little in their scope. Currently, the Oxford English Dictionary definition states that 'boundary' refers to "that which serves to indicate the bounds or limits of anything whether material or immaterial; also the limit itself" (Oxford English Dictionary, 2017, para 1). Alternatively, the Chambers Concise Dictionary, states that a 'boundary' is "a line or border marking the farthest limit of an area" (Brookes, Munro, O'Donoghue, O'Neil and Thomson, 2004, p144). It can also be used to describe "a final or outer limit, often an immaterial limit, to anything" (Brookes et al., 2004, p144). However, when the concept is applied to relationships defining it becomes much more difficult (Sommers-Flanagan, Elliott and Sommers-Flanagan, 1998).

The field of counselling and psychotherapy has always struggled with the definition and application of boundaries (Zur, 2010). In the United States of America (USA) more research has been published; however, the American literature on boundaries is often written for therapists who are psychiatrists and psychologists. For example, Gutheil and Brodsky (2008) state that a "*boundary* is the edge of appropriate behavior at a given moment in the relationship between patient and therapist, as governed by the therapeutic context and contract. It may be defined by the physical, psychological and/or social space occupied by the patient in the clinical relationship" (p18 - italics are authors own). Psychiatrists and clinical psychologists generally work within a medical context which is bound by rules, regulations and procedures which are different, currently, from those in which most counsellors' work in the UK. Thus, although it is useful to consider this literature, particularly since there is limited UK based research, it is important nonetheless, to be mindful of the slightly different context in which the work is based.

In the UK, Proctor (2014) says the most common use of the boundary concept in counselling and psychotherapy is "to refer to the limits of the therapy relationship" (p154). Similarly, Feltham (2010) refers to 'boundaries' being synonymous with the idea of 'frames' (p18).

However, other UK based practitioners and researchers view the concept differently. For example, Bond (2015) states that boundaries "[s]et the limits between ethically acceptable and unacceptable influence over others or the line between acceptable and unacceptable relationships" (p305). Whereas Sarkar (2004), a UK psychiatrist, advises that "the term boundary in professional practice refers to the distinction between professional and personal identity" (p312) serving only one purpose – the safety of those on either side. Davies (2007) acknowledges that boundaries can occur *between* a client and counsellor, but notes that the term boundary has also been used to describe internal psychological processes, as for example, in psychodynamic theory; the id and the ego.

Perhaps Zur (2010), writing from the perspective of American psychotherapy, offers the most realistic – if vague – definition when he states that what "unifies all the definitions of boundaries is the essential aspect that they differentiate between two or more physical – actual or elusive – abstract entities" (p3).

Certainly, there are many interpretations of 'boundary' and its application towards therapy; of which the majority of definitions and discussions within the literature can be argued to have developed from a 'top-down' perspective. That is they are defined and debated by professional organisations, and academics in journals and textbooks rather than sourced from the counsellors themselves.

Nonetheless, despite the lack of clarity and agreed single definition, defining what is meant by boundaries is important if discussions surrounding effective research and practice are to be progressed. Moreover, taking account of counsellors' experiences and perspectives is surely a vital part of this progress. Certainly, some professional organisations have started to include counsellors and therapists in the construction of their literature (e.g. BACP, 2016a) but there is still a long way to go.

Having outlined some of the understandings and definitions of 'boundary' so the next section considers the current literature on boundaries within the field of counselling using five discussion points identified in the literature: (1) Boundaries and Counselling Ethics; (2) Exploitation and Abuse; (3) Boundary Issues; (4) Types of Boundaries (5) An alternative view of boundaries?:

Discussion Point 1: Boundaries and Counselling Ethics

Introduction

Boundaries are inextricably linked with ethics in counselling and psychotherapy. As Reeves advises *"[f]ew would argue that boundaries lie at the heart of ethical counselling and psychotherapy and that, without them, not only is the potential for change undermined, but the likelihood of harm to the client is increased"* (Reeves, 2011, p247). This quote is powerful not simply as it asserts the synonymous nature of boundaries and ethical practice, but also as it challenges us to question potential boundary issues such as the process of change and harm to the client. Building on Reeves' comments this thesis will argue that boundaries relate to much more than just ethical practice and that focusing on the 'ethical' part may lead the discussion of boundaries to become too narrowly focused.

Initially, however it is relevant to examine the concepts of boundary and ethics and how they relate to one another in the field of counselling and psychotherapy. There will also be a consideration of how the boundary concept is used and how it relates to current ethical codes.

The term 'boundary issue' is discussed and an argument put forward that it can be better used as a term for considering boundary related encounters because of its neutral focus compared to other words such as 'violations' or 'crossings'; which are preferred terms currently. A working definition of 'boundary issue' will then be proposed to enable further discussions in this thesis.

First, it is important to provide a working definition and understanding of 'ethics' relevant to this thesis.

<u>Ethics</u>

The field of ethics or 'moral philosophy' is an area of philosophy that covers the morality of any action. Moral philosophy is effectively the discussion between what is 'right' and what is 'wrong' (Bond, 2010), or what is 'good' and what is 'evil' (Rosenbaum, 1982). So, if "a boundary may parsimoniously be defined as the 'edge' of appropriate behaviour" (Gutheil and Gabbard, 2003, p416), then the area of ethics surely defines where some of those edges are. The discussion of boundaries often crosses over into the area of ethics (Bond, 2008; Bond, 2015; Owen, 1997; Proctor, 2014; Smith, Collard and Nicholson, 2012), because boundaries are often considered part of any ethical construct (Zur, 2004). For example, boundaries can be referred to as a set of professional limits (Gutheil and Gabbard, 1993; Sommers-Flanagan, Elliot, Sommers-Flanagan, 1998; Reamer, 2001), which can itself be considered a specific form of ethics (Rosenbaum, 1982).

Pope and Vasquez (2016) state that for therapists using ethical intelligence will always include "thinking clearly about the boundaries of our relationships with our clients" (p167). Therefore, "…when the concept of boundary in professional helping relationships is considered in the light of applied ethics, it is clear that the two are very much intertwined" (Sommers-Flanagan, Elliott and Sommers-Flanagan, 1998, p38). The term 'boundary' is used to refer to both standards and ethics in counselling practice (BACP, 2016a, c, d; Bond, 2008; Bond, 2015; Kent, 2013; Pope and Vasquez, 2016; Proctor, 2014; Smith, Collard and Nicholson, 2012; UKCP, 2009). This can often focus on what is and what is not acceptable behaviour for counsellors towards their clients (Bond, 2015; Kent, 2013). However, by constantly viewing professional ethics in terms of the boundary between 'good' or 'bad' practice it can be argued that the profession runs the risk of unnecessarily narrowing its approach towards ethics because the focus becomes the minimum level of acceptable practice rather than a discussion of the broad array of ethical issues which pervade every aspect of therapy (Bond, 2008). Certainly, the profession has moved away from a 'black and white' view of ethics towards advocating a more reflective form of practice (e.g. Gabriel, 2016b). Nonetheless, the boundary concept still appears to be closely associated with discussions around good and bad practice (e.g. Bond, 2015; Proctor, 2014).

Ethical Codes

Professional codes of ethics are there to "formally articulate professional relationship boundaries" (Sommers-Flanagan, Elliot and Sommers-Flanagan, 1998, p38). For counsellors these codes exist to not only govern their practice but to offer protection to the client (and to a lesser extent the counsellor) (Kent, 2013; Proctor, 2014). In the UK there are a variety of ethical codes which offer governance to counsellors and therapists. The main ones are (in alphabetical order): British Association for

Counselling and Psychotherapy (BACP, 2016), British Psychological Society (BPS, 2010), and Counselling and Psychotherapy in Scotland (COSCA, 2014) and United Kingdom Council for Counselling and Psychotherapy (UKCP, 2009).

As previously stated the boundary concept has gained increasing prevalence within the counselling literature in the UK. Another way of considering its rise in prominence is to look at the current ethical frameworks. During the writing of this thesis the BACP code has been reviewed and updated. The current code uses the term 'boundary' five times in reference to ethical behaviour (BACP, 2016a) this is in comparison to the previous code where it was not used once (BACP, 2013a). This in itself suggests that the BACP now considers boundaries to have a much higher level of significance in relation to ethical behaviour.

The UKCP refers to 'boundaries' twice within their Ethical Principles and Code of Professional Conduct (2009), as does COSCA (2014). Although all of these codes use the term 'boundary' none of them defines what is actually meant. The UKCP advises that therapists hold responsibility for the clarification and management of boundaries in dual relationships. In addition, they are required to ensure they are competent to practice by ensuring that they know the boundaries (or limits) of their expertise. COSCA associates boundaries as a contributory factor towards the practice framework as well as providing safety for client and counsellor.

The BACP code specifically refers to the maintenance of professional and personal boundaries as an important aspect of counselling practice. It advocates having consistent boundaries that are in line with the aims of the therapy; avoiding dual relationships; ensuring that management of boundaries is for the benefit of the client; and that there is an assessment and discussion of boundary related issues from the

outset (BACP, 2016a). Furthermore, supervisors will be expected to evidence good practice "particularly with regard to expected levels of competence and professionalism, relationship building, the management of personal boundaries, any dual relationships, conflicts of interest and avoiding exploitation" (BACP, 2016a, para 53) with a similar proviso for trainers and educators. The UKCP also refers to boundaries as important for therapists when taking responsibility for managing dual relationships (UKCP, 2009).

Despite their additional reference to boundaries (and the associated importance) the BACP do not offer any detailed discussion of boundaries within their literature. Interestingly, the BACP did offer an information sheet about what is meant by 'professional boundaries' that was originally only available to BACP members (Kent, 2013) but is now offered to clients who access the BACP counsellor and therapist register (BACP Register of Counsellors and Psychotherapists, 2016). This document is dated 2013, although previous versions have existed (Kent, 2010). To understand how it was produced I attempted to contact the author via the BACP but without success (BACP, Personal Communication- 20th November 2012). The most recent version has been updated with renewed BACP references within the text (i.e. up to date referrals to the professional code and information sheets). However, there is no amendment to the discussion on professional boundaries in the later version.

This is surprising in a context of increased emphasis from the BACP in their ethical code (BACP, 2016a); and that establishing and maintaining boundaries can be considered one of the most challenging aspects of professional practice (Coe, 2008). Furthermore, the BACP do not record how many practitioners have downloaded their information sheets, which makes it impossible to consider the level of demand for this information, or assess how useful practitioners find it.

The impact of ethical codes on counselling practice is also unclear. Carey (2016) argues that ethical codes and therapeutic boundaries should be used together when making decisions in counselling practice. However, there is no specific research which explores how counsellors use ethical codes and the impact that it has on their practice or their ethical decision making in the UK. Certainly the consultation of ethical codes are advocated as part of many models of ethical decision making in the counselling literature (for example Bond, 2015; Pope and Vasquez, 2016) but there is little or no research evaluating how far, how effectively or with what impact, they are used.

Ethical codes reflect the current standards of care required of counsellors and therapists towards their clients. Ethical codes are increasingly using the boundary concept to inform and represent these standards (BACP, 2016a). However, evidence indicating the impact of ethical codes on counselling practice is limited. Therefore, the impact of any changes to these codes (including the increased use of the boundary concept) is also unclear. This gap in the research literature means the impact of both ethical codes and the boundary concept on counselling practice is an important area to research. This thesis aims to focus on the latter.

Ethical Decision Making versus Boundary Decision Making
It is important to note that there is little practical advice available for counsellors when making boundary related decisions. This is surprising when managing boundaries is one of the most common challenging aspects of professional practice (Coe, 2008). This is further evidenced by the added difficulty of managing boundaries when working with vulnerable client groups. For example: when working with children rather than adults (Prever, 2010); working with victims of abuse (Sanderson, 2013); clients with serious mental health problems (Aiyegbusi & Kelly, 2012); or suicidal clients (Reeves, 2010). Although the BACP are currently updating their information and guidance

leaflets and are introducing an increased range of relevant Continuous Professional Development (CPD) training modules, there is a clear need for relevant guidance and support.

The importance of boundaries is surely increased when working with these very vulnerable clients. Furthermore, as therapy and counselling are often completed in private, with very little independent oversight or observation this means that counsellors must rely instead on their own professional and ethical decision making practice (Olsen, 2010). This highlights the need for counsellors to be able to access clear, practical and meaningful advice about boundary related decisions that is based in relevant research. One of the most common questions about the BACP Ethical Framework concerns the 'appropriate' boundaries in relationships (Mitchells, 2016). This further supports the argument that counsellors need practical support in making boundary related decisions because if counsellors are unaware of the appropriate relationship boundaries then they will have difficulty in making decisions about them!

Certainly there are models which support ethical decision making for counsellors (e.g. Bond, 2015; Davies, 2015; Gabriel, 2016a; Pope & Vasquez, 2016; Proctor, 2014). However, there are a limited number of models which support counsellors in specifically making boundary related decisions (e.g. Carey, 2016). Furthermore, those that do exist are created from top-down perspectives rather than from the understanding and experience of practitioners themselves. Despite boundaries often being linked to ethics the current literature often discusses ethical decision making separately to their discussion of boundaries (for example, Bond, 2015; Proctor, 2014).

Ethical anxiety experienced by the therapist can be closely associated with an ethical dilemma (Proctor, 2014). Ethical models aim to reduce or avoid this anxiety by

supporting the counsellor to reflect on the presenting issue (Gabriel, 2016a) and the benefit of these models is that they offer a structured and systematic approach to ethical problem solving which incorporates multiple perspectives (Gabriel, 2016a; Proctor, 2014). However, they still require interpretation and application by the counsellor themselves. Furthermore, if they are used by counsellors to approach boundary issues they will only focus on the aspect of ethics rather than including aspects which may not be considered 'ethical' in nature. Surprisingly, boundaries are neither mentioned nor referred to in the BACP best practice guidance for ethical decision making (Gabriel, 2016b). Therefore, there is a lack of clarity for counsellors about the relationship between making boundary related decisions versus ethical decision making. In this vein it is unclear if counsellors understand them to be one and the same.

Discussion Point 2: Exploitation and Abuse

The concept of 'boundary' is often used as a way to mark out the limits of appropriate or inappropriate behaviour of counsellors (Bond, 2015; Kent, 2013; Proctor, 2014) with one of the assumptive aims being to protect clients from exploitation and abuse a central aspect of all counselling ethical standards and codes of practice (BACP, 2016a; COSCA, 2014; Kent, 2013; UKCP 2009). Fundamentally, professional boundaries and professional ethics are about protecting the client and safeguarding them from harm (BACP, 2016a; Bond, 2015; Kent, 2013; Proctor, 2014; Sarkar, 2004). The client is protected from exploitation through the expectations that are set for counsellors, including their training and practice (Owen, 1997). Usually this means the protection of the emotional and mental safety of the client (Kent, 2013), but it can include other types of protection. For example, the professional boundary of

confidentiality means clients are protected from their information being shared with other parties.

What is Abuse?

The term 'abuse' generally refers to an act that hurts or injures someone or something by acting wrongfully or improperly (Brookes et al., 2004). This can be from the improper usage or unreasonable usage of something (such as power or position) or through to the physical or mental maltreatment of someone. This covers a broad expanse of behaviour and examples. Therefore, there can often be confusion about what is meant by 'abuse'. Abuse can include, but is not limited to: psychological; physical; sexual; financial; emotional and spiritual aspects (Dupont, 2004; Home Office, 2013; Oakley & Kinmond, 2013; O'Hagan, 2006). There is also confusion between different types of abuse. For example, despite numerous differences 'emotional' and 'psychological' abuse can often be used interchangeably (O'Hagan, 2006).

For Dupont (2004) "abuse is the *misuse of power*" (p13) [italics authors own]. Current definitions of abuse are expanding to include a more detailed acknowledgment of power. For example, the government definition of domestic violence and abuse has been updated to include the elements of coercion and control. It is now defined as "any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality" (Home Office, 2013, p2). Similarly, Oakley and Kinmond (2013) define spiritual abuse as "coercion and control of one individual by another in a spiritual context" (p214). Power in therapy is often argued to be inadvertently balanced towards the counsellor (Masson, 1989) and undoubtedly, power plays a significant role within the therapeutic relationship.

However, Proctor (2002) argues that the positive applications of power (and its dynamics) in the therapeutic relationship can often be ignored.

Similarly, to the general population the exploitation and abuse of counselling clients by therapists can take many forms such as sexual, financial and emotional (BACP, 2016a; UKCP, 2009) as well as spiritual and physical harm (BACP, 2016a). The avoidance of abuse and exploitation of clients is a main feature of all ethical codes (e.g. BACP, 2016a; UKCP, 2009) and indeed, controversially, some authors argue that *all* counselling is abusive because of the power held by the counsellor within their role (Masson, 1989). So, arguably, boundaries aim to protect clients from harm by their therapists (Kent, 2013). Therefore, the literature surrounding the abuse of clients of talking therapies can often be characterised in terms of 'broken boundaries' (Richardson, Cunningham et al, 2008) or 'boundary violations' (Glass, 2003). (For a discussion on the extent of abuse in the UK please see *Appendix A, p319*).

What is a boundary violation?

Although this research does not specifically focus on the subject of boundary violations it is acknowledged that this is reported in a significant part of the literature on boundaries in therapy and therefore, it warrants some discussion.

Unethical behaviour from therapists has become synonymous with the phrase 'boundary violations' (Glass, 2003). Although the literature on boundary violations (similarly to the literature on boundaries) has largely resulted from the USA (Levine, 2010) the term is now also used within the UK counselling literature (e.g. Bond, 2015; Martin, Godfrey, Meekums and Madhill, 2011; McLeod, 2013; Proctor, 2014). However, the majority of the discussion (and research) surrounding boundary violations has been about practitioners of talking therapies within the USA and these discussions have often been about psychologists, psychiatrists, psychoanalysts or

other psychotherapists rather than counsellors per se (for example Gabbard, 2016; Gabbard & Lester, 2003; Glass, 2003; Gutheil & Brodsky, 2008; Gutheil & Gabbard, 1993; Levine, 2010; Norris, Gutheil, & Strasburger, 2003; Simon, 1995). This means the understanding of the concept of 'boundary violation' in the UK is limited, in particular its relationship to counselling practice.

Historically, the literature on boundary violations has been centred on the subject of sexual abuse and exploitation of clients by their therapists (Gutheil and Brodsky, 2008; Pope and Vasquez, 2016; Sarkar, 2004). The literature on this subject has mainly originated in the USA. The term 'boundary violation' was originally used to refer to sexual relationships between a therapist and their client (Gutheil and Brodsky, 2008). Discussions of sexual boundary violations have, historically, been a taboo within the field of counselling and psychotherapy, with Pope and Bouhoutsos (1986) calling it a 'persistent denial' (pvii). (For a discussion on the history of sexual boundary violations in therapy see *Appendix B, p321*).

The extent of sexual exploitation of clients by their counsellors in the UK is unclear as incidents are likely to be underreported if this follows the same pattern as in other professions (Halter, Brown and Stone, 2007). This is supported by the fact that complaints about client sexual exploitation are relatively minor in the UK (Khele, Symons and Wheeler, 2008) compared to say the figures in the USA. Bond (2015) speculates, from his own experience, that rates of sexual exploitation by clients are likely to be much higher with professionals who are not regulated by the BACP or another professional organisation. Certainly, this type of exploitation by counsellors lacks detailed research (Halter, Brown and Stone, 2007).

Adshead advises that boundary violations "represent a failure of ethical reasoning by professionals" (2012, p13). This advice follows Sommers-Flanagan, Elliot and Sommers-Flanagan, (1998) who noted that for professionals there are some boundaries which are so essential to that professional relationship and are of "such clarity and precision that to violate them essentially redefines the relationship", p38). It is these boundaries which when they are broken violate the trust placed in the professional and they result in harm to the client. (For a discussion on potential reasons for boundary violations to occur please see *Appendix C, p323*).

The boundary of competency

Working within the boundaries of competency - that is working within the limits of their professional capabilities - is an important aspect of professional practice (Bond, 2015; Reeves, 2013). The BACP Ethical Framework states that counsellors must work to professional standards by working within their competence (BACP, 2016a). Professional boundaries would include the competence, knowledge and skill of the therapist (Carey, 2016).

Competence can be defined as "the effective deployment of the skills and knowledge needed to do what is required" (BACP, 2010, p4). Reeves (2013) breaks down this definition into two parts. The first is the 'deployment' of knowledge and skills which 'belong' to the therapist. This means the therapist is responsible for being competent in the relevant knowledge and skills to fulfil their role as a therapist including assessing risk, having the appropriate listening skills and empathic ability. The second is the 'what is required' aspect of this definition which Reeves says relates to what the client wishes to achieve in therapy i.e. their therapeutic goals.

Research suggests that boundary dilemmas can challenge counsellors and therapists sense of competence in their practice (e.g. Jenkins, 2003; Reeves and Mintz, 2001).

Owens, Springwood and Wilson (2012) identify therapist competency as a key boundary for counselling and psychotherapy practice. Reeves (2013) suggests that it is more common for counsellors to *feel* incompetent rather than *be* incompetent in their practice, which may allude to the emphasis that counsellors place on reflective practice. Counsellors' consideration of the whole interaction of the therapeutic encounter is likely to lead to them questioning their work and themselves.

Feelings of incompetence can be described as "moments where a therapist's belief in his or her ability, judgement and/or effectiveness is diminished, reduced, or challenged internally" (Theriault and Gazzola, 2005, p12). Feelings of incompetence appear in both novice (Thériault, Gazzola and Richardson, 2009) and experienced therapists (Thériault and Gazzola, 2005) and influence the development of the therapists professional-self (Thériault and Gazzola, 2010). So, certainly, whilst reflective practice is to be encouraged, it is also surely important that a counsellor works with a non-judgemental supervisor with whom s/he has an effective relationship in order that unhelpful incompetency's are addressed, but also that inappropriate feelings of incompetence are allayed.

Counsellor Protection
Boundaries aim to keep both clients *and* counsellors safe (Kent, 2013). However, the overwhelming discussion of boundaries is their use in keeping clients safe rather than counsellors. There is some limited discussion in the literature on the use of boundaries for the protection of the counsellor. For example, Bond (2015) discusses the personal safety of the counsellor from potentially violent clients or the risk of emotional burnout but does not necessarily relate these to boundaries but rather the minimum standards of care for which the counsellor is responsible.

Barnett (2008) proposes that there are three types of ethics: positive ethics when professionals aim to achieve the highest possible ethical standards; risk management which still has client outcomes at its heart but is more directed towards reducing the risks to the therapist with regard to complaints and finally, defensive practice which focuses on the protection of the therapist rather than the client. Barnett (2008) argues that positive ethics should be the preferred choice. However, this argument is challenged by Proctor (2014) who argues that ethical practice should include aspects of all three to enable the management of all the necessary needs which suggests that protecting the therapist and reducing risks towards the therapist are just as important as high ethical standards for clients.

Boundaries are not just about Abuse

Arguably the focus on abuse and violations in the counselling literature takes the discussion away from the everyday boundary experiences that counsellors face in their practice (Bond, 2008; Totton, 2010). Clearly, the research into why counsellors abuse clients and to what extent this is a problem in the UK needs further investigation. However, because the literature focuses mainly on this aspect of boundaries it can distract from discussion of other aspects. One reason for this may be because it is easier to consider the outer lines of acceptable behaviour for counsellors rather than considering some of the more nuanced issues which occur (Bond, 2008; McLeod, 2013). Opportunities for practitioners to learn about boundaries through client complaint may be limited because reports of cases can use analysis and theory which distances the counsellor from the client's story (Bates, 2006; Gabbard and Hobday, 2012) whereas a focus on risk management from counsellors can distract from the relationship between client and counsellor (Lazarus, 1994). Proctor (2014) argues that "a major difficulty in discussions of 'boundaries' is the danger of therapists constraining

[them]selves to avoid potential abuse, but totally missing the danger of neglect" (p159). Furthermore, to stop counsellor-client relationships becoming abusive it is important to understand how therapists understand and experience all aspects of boundaries in their practice (Hetherington, 2000). Twenty years ago Webb (1997) recommended that research should focus on qualitatively exploring not just situations of abuse but issues to do with boundary management. However, the research into how counsellors understand and experience boundaries outside the area of abuse is still very limited.

This thesis argues that the discussion of boundaries should be broadened further to include other aspects of 'boundary' that are not necessarily related to abuse or ethics per se but are still important aspects of the therapeutic encounter. One way to broaden this discussion is to reconsider the terminology that is used surrounding boundaries. This argument is considered next.

Discussion Point 3: Boundary Issues: ethical dilemmas or points of reflection?
There is some discussion of the concept of 'boundary issues' within the counselling and associated literature which is relevant to review here. A working definition of 'boundary issue' is detailed at the end of this section with further arguments for its use being detailed in chapter five later in this thesis.

As noted earlier, it is difficult to agree on a single definition of 'boundary' and thus, the task of defining the term 'boundary issue' is even more problematic. 'Issues' often refer to specific and important problems that may require a choice or decision to resolve them (Bond, 2015). Boundary issues have developed from psychoanalytical theory however they are no longer limited to the use of psychodynamic therapy (Epstein, 1994). Reamer (2001) advises that boundary issues are problematic to all helping professionals and occur when practitioners establish multiple or dual relationships with their clients, such as additional professional, social or business relationships outside

of the practitioners helping role. In the context of therapy boundary issues can often be associated with specific ethical issues or dilemmas that the counsellor or therapist may have to deal with (Proctor, 2014).

Ethical boundary issues often span a broad spectrum, from simple mismanagement through to serious abusive violations (Pope and Vasquez, 2016) whereas ethical decisions surrounding boundaries often centre on the breaking of boundaries. Boundary issues, for Reamer, are matters that breach the original helping role and although not always harmful are likely to raise issues of conflict or concern. Symons and Wheeler (2005) state that "[t]herapeutic boundaries and their management can give rise to difficult dilemmas for counsellors" (p19). Boundaries in therapy can create issues because: they can catch therapists 'off guard'; opportunities to cross boundaries can feed into our hidden needs and desires; the need for clarity about boundaries can be misinterpreted as the need for fixed and rigid boundaries; boundary issues can invoke anxiety and fear in counsellors; and there is relatively little practical guidance in making decisions when it comes to boundary issues (Pope and Vasquez, 2016). The literature on boundaries often highlights examples of boundary issues for example the use of touch in therapy, sexual relationships with clients or former clients; the therapist receiving gifts or the role of dual relationships (Bond, 2015; Gutheil and Gabbard, 2003; Pope and Vasquez, 2016; Proctor, 2014). If we conceptualise boundary issues in terms of areas of ethical conflict we can see how the above examples may fit into this definition.

Arguably, Gutheil and Gabbard's (1993: 2003) idea of 'boundary transgressions' can also be considered a 'boundary issue' because of their ethical nature. They separate boundary transgressions into two types: violations and crossings. As previously detailed the first of these, boundary violations, are a form of abuse which exploits the

client or is harmful in some way. However, Gutheil and Gabbard approach this point from the view of the client (i.e. any boundary transgression which is harmful to the client is a violation, even if the harm is unintentional). The second category, called boundary crossings, are a nonthreatening form of transgression which will result in *no harm* to the client and possibly a therapeutic effect (Gutheil and Gabbard, 2003). Gutheil and Brodsky (2008) state that boundary crossings can be considered: a departure from the usual norms of therapy; benign deviations from usual practice; harmless; non-exploitative; and may support or advance therapy. In contrast, boundary violations are: not done in the interests of the client; unwarranted; dangerous; exploit the client; take therapists out of their professional role. 'Good intentions', they state, count for little when deciding if a boundary has been violated or crossed. However, this language can be unhelpful because it encourages discussions of boundary issues to centre on practice which deviates from the norm arguably implying a negative connotation. This is problematic particularly when boundary crossings can be an important part of well-constructed therapy (Zur, 2010). For example, therapist self-disclosure or an extension of time boundaries may be regularly used by some therapists as part of their practice.

For Proctor there "is a dispute in the literature about the distinction between crossings and violations or between technical and moral matters" (2014, p 168). Goldberg (2008a, b), discussing psychoanalytical therapy, argues that a distinction should be made between moral wrongdoings and technical mistakes in therapy believing that moral wrongdoings relate to boundary violations whereas technical mistakes are common and should not be considered a violation. Furthermore, Goldberg argues that technical mistakes often result in feelings of shame or guilt in the therapist and

therefore become categorised as 'wrong' and a moral failure rather than as what they are - a mistake by the therapist.

Gabbard (2008) argues, in response to Goldberg, that it is difficult to separate the issues of morality and technique when discussing boundaries because they are inevitably linked, each influencing the other. Friedman (2008) agrees with Goldberg that the boundary concept is no longer helpful when discussing technical mistakes versus moral errors but still believes it has value when discussing ethics and defining the line of what constitutes exploitation and abuse. However, Greenberg (2008) argues that technical error can only be understood in terms of therapeutic tradition whereas boundary violations should transcend these differences and aim to be universally understood by all therapists. Furthermore, boundary violations are not just viewed from the perspective of the counsellor as the perpetrator of abuse. Boundary violations by clients (i.e. when a client breaches therapeutic boundaries) can be used by psychodynamic counsellors as a means to understand unconscious motivations and provide insight into the clients other relationships (Symons and Wheeler, 2005).

Gabriel (2005) suggests that when considering any extensions to therapeutic work that therapists consider whether they are 'non therapy' or 'extra therapy' issues; the former being client-counsellor interactions which are not related to the therapy work, with the latter being additions to the therapy (but still bounded by the contracted counselling relationship). McLeod (2013) argues that the focus on boundary violations (particularly sexual) has meant a confusion between ethical issues and boundary issues and argues that not all boundary issues are necessary ethical in nature for example, extending time boundaries.

Gutheil and Brodsky (2008) advise that "the therapist not only protects ethical boundaries but often advances the therapy as well" (p37) through their use of boundaries. Rather, it may be more useful to define the concept 'boundary issue' in much broader terms to include not only ethical dilemmas but other aspects of therapy. That is to consider a working definition of 'boundary issue' as an aspect of counselling or therapy which is an ethical or therapeutic point of reflection. For example, something that causes an ethical dilemma, a point of reflection in the therapy, or an issue which is in itself an opportunity to further the therapy itself.

Discussion Point 4: Types of Boundaries

Introduction

The term 'boundary' when applied to counselling enables discussion of many different aspects of a therapeutic encounter (McLeod, 2013). Brown and Stobart (2008) imagine "a series of concentric circles that, like the layers of an onion, define and encircle the therapeutic experience" (p83). These start with the outer circle of legal restraints, government mandates and cultural expectation which is followed by ever decreasing levels of boundary containment - such as: professional bodies, ethical codes and training and institutional requirements - as they approach the centre of the therapeutic encounter. This discussion point will examine the concept of boundary and how it can be applied to different aspects of the therapeutic encounter. This covers structural and interpersonal boundaries; the role of therapeutic tradition in practice; and the conflict of rigid versus flexible boundaries.

Structural Boundaries

Boundaries can be considered the framework or the structure of the therapeutic encounter (Davies, 2007); the 'therapeutic frame' (Zur, 2010) or relational factors (i.e. the generic and universal rules of engagement with a client (Gutheil and Brodsky,

2008). Structural boundaries can be viewed as the outer limits of the therapeutic relationship, that is, the standard rules and expectations that are held in all therapeutic relationships which 'hold' the therapy together (Brown & Stobart, 2008; Gray, 1994; Kent, 2013). The 'structures' in this sense relate to the actual mechanics of the counselling sessions. For example, the time limitations set for the session or the frequency of the session, it can also include contractual expectations and common limits (such as confidentiality). This set of boundaries is drawn around the client and therapist. Carey (2016) calls these contextual boundaries (for example appointments and location of the sessions). Clear boundaries aim to contain both the therapeutic process as well as the client's fears and anxieties (Smith, Collard, Nicholson and Bayne, 2012). The boundary concept can be used to represent structural 'containment' at multiple levels

Structural boundaries include fee, venue, time, number of sessions, with two major examples being the contract and confidentiality. The concept of boundary can be used practically to establish the expectations of therapy for clients (Smith, Collard, Nicholson and Bayne, 2012). One of the main ways that boundaries are established within the therapeutic relationship is through a contract (Sills, 2006). The contract can act to define the boundaries between counselling and other relationships, as well as provide a framework to help contain the counselling process (Sills, 2006). Although at first glance the contract may seem purely structural in nature, expressing time limits, fee's etc it can also relate to practice, either through goal setting (Davies, 2007) or use of psychological contact (i.e. body language).

Confidentiality can be considered a structural boundary which aims to protect client information from being unduly shared with others. It "acts as a shield to protect client autonomy by putting them in control of how they use their counselling in their everyday

life" (Bond, 2015, p169), therefore acting as a boundary that holds the therapeutic encounter both in terms of the structure of therapy but also in terms of client safety. It is one of the most valued boundaries in counselling practice (Jenkins, 2003). Psychoanalysis has historically held confidentiality sacrosanct with some therapists risking criminal sentences to protect it (Bond, 2015). Confidentiality therefore often has a dominant place in the counselling literature (e.g. Bond, 2015; Bond & Mitchels, 2015, 2016; Proctor, 2014).

Bond and Mitchels (2015) advise that the most ethical approach to confidentiality is informed consent, which involves explicit consent from the client about what communications can be made and to whom whilst also "clarifying where the boundary of the obligation of confidentiality lies" (p21). Bond (2015) suggests that confidentiality is "probably the issue that raises the most ethical and legal anxiety for counsellors" (p169).

Interpersonal boundaries

Boundaries can also be considered from an interpersonal perspective (Zur, 2010); they happen *between* the counsellor and the client (rather than around them as with structural boundaries); and are part of a counsellors practice (Davies, 2007). Gutheil and Brodsky (2008) also call these pragmatic factors which are the individualistic factors which influence the therapy, such as counsellor training (Webb, 1997), therapeutic tradition (Jacobs, 2010; Mearns and Thorne, 2013), their attitude and decisions (Feltham, 2010); their professional identity (Ronnestad & Skovholt, 2003; Skovholt & Ronnestad, 1995); their personality (Hartmann, 1997) and their personal and cultural experiences (Gabriel, 2005); or the alternative concepts and ideas of the therapist (Gutheil and Brodsky, 2008). McLeod (2013) states that "[p]otentially, the metaphor of an interpersonal 'boundary' provides practitioners with a powerful

conceptual tool with which the nature of the therapeutic relationship with a client can be examined" (p422).

Intrapersonal Boundaries

The use of boundaries as part of a theory towards internal psychological functioning is central to many counselling traditions (Davies, 2007). Terminology may differ between different theoretical positions, for example calling it an intrapsychic structure (Hermansson, 1997), or *intra*personal boundaries (Davies, 2007). However, it exists within all counselling theories, some more obviously than others. Hermansson (1997) identifies Transactional Analysis (TA) as having the most expressed application of boundaries on internal psychological functioning theory. However, possibly the most obvious example is from the psychoanalytic tradition; the model of the ego, id and superego recognised as three separate psychological structures which span over three different 'levels' of consciousness: the unconscious, the preconscious and the conscious.

Therapeutic tradition

The concept of boundary in therapy was originally associated with psychoanalysis and has been used within the field "to denote the demarcation between self and object components in the intrapsychic world, the boundary between the biological and psychological, a dimension of the ego, and a component of psychoanalytical process" (Gabbard, 2016, p1). A compilation of Freud's lectures on the basic principles of psychoanalysis makes no references to boundaries in terms of therapeutic practice (Freud, 1920). Freud does however establish the ground rules for psychoanalysis. It is these rules to which Milner (1952) applies the metaphor of the frame which is also associated with the concept of 'boundary'. The therapeutic frame is most commonly

used in psychodynamic counselling and can be viewed as the framework for the therapeutic encounter (Gray, 1994).

Epstein (1994) advises that as per "any other interpersonal process, every psychotherapeutic encounter has a frame that delineates the purpose and meaning of the relationship" (p17). For psychodynamic counselling it is necessary to have "a secure frame for the work that holds boundaries as sacrosanct, both to ensure ethical practice and to provide a vehicle through which unconscious processes can be recognized and understood" (Symons and Wheeler, 2005, p19). The therapeutic frame is effectively the "set of boundaries which is set up round the therapeutic relationship" (Jacobs, 2010, p151). This can refer to a range of procedures and limitations within the therapeutic encounter such as ensuring that sessions are held consistently and at a regular time (Davies, 2007). For this purpose the closest analogy would be towards a set of rules that are the basic foundation of each therapeutic encounter.

However, Gray (1994) argues that the rules of practice must not be implemented arbitrarily without a consideration of the personal aspects of each client. Arguably then the frame is similar to Davies (2007) structural boundaries and also consistent with Gutheil and Brodsky's (2008) relational factors of therapy as it forms the basic structure of therapy. However, each therapeutic tradition will differ in the level of importance that they apply to the frame; they will agree on some of the basic boundaries such as no sexual relationships with clients but this may be where agreement ends. For this reason 'the frame' is usually considered part of psychodynamic theory rather than other therapeutic traditions.

The concept of boundary in psychoanalysis can often be represented as the therapist having a rigid, unwavering style of relating towards the client (Owen, 1997). This is in

line with the concept of the frame which aims to contain and hold the therapy securely. A secured frame reportedly offers: safety for the client; strong interpersonal boundaries; devotion to the therapeutic needs of the client and therapists and a rejection of 'inappropriate emotional needs'; a healthy relationship with the therapist (i.e. for benefit of the client); and inherent support for the client and therapists sense of self and identity (Langs, 1990).

Certainly, the current psychodynamic literature still advocates the use of the therapeutic frame as an important aspect of this theoretical orientation (for example Symons and Wheeler, 2005; Gray, 1994; Jacobs, 2010). Psychodynamic counsellors aim to understand the clients' unconscious motivations by exploring their attempts to attack the therapeutic frame or violate boundaries (Symons and Wheeler, 2005). Therefore, the implementation and maintenance of boundaries in psychodynamic therapy is still an important aspect of implementing the frame and for developing the therapeutic relationship (Jacobs, 2010).

In contrast, the concept of boundary in humanistic therapy can often be represented as warm, relaxed and unrestricted (Owen, 1997). Humanistic therapies are therefore more 'tolerant' of deviations from the traditional therapeutic role (Gabriel, 2005). Mearns and Thorne (2013) argues that person-centred counselling aims to 'equalise' the relationship between counsellor and client and that this endeavour is a priority. Thus creating an environment where the client feels empowered to: find their own resources, find their own sense of direction and take control of their life. For Mearns and Thorne "[b]oundaries are established to facilitate these outcomes" (2013, p203), and are therefore always open to renegotiation dependent on the needs of the client. This therefore requires consultation with the client. Sule (2007) is one of the few authors who attempts to address the issue of 'boundary' in person-centred counselling

in some detail arguing that the concept creates three interdependent spaces of reflection the internal spaces of the client and counsellor and the reflective space that they share. Mearns and Thorne (2013) argue that fundamentally the basic therapeutic boundaries remain the same as other orientations although in person centred counselling they are open to change as part of the therapeutic process. Mearns states that this means "person-centred counselling is in its very essence a deeply ethical activity and is utterly at variance with a rule-bound or manual dictated practice which places inflexible regulations or procedures above the emerging needs of persons in relationship" (p203). Humanistic therapy, then, sees boundary "not as a 'rule for remaining separate' but as an indicator of a place where contact and 'meeting' might occur" (McLeod, 2013, p422).

Feltham (2010) says that there are limited agreements on boundaries and that many of the differences reflect the different rationales of different modalities. However, it is all too easy to create an unrealistic characterisation of an individual approach which is neither meaningful nor representative to most practitioners who use it (Feltham, 2010). Arguably, this is also true when considering how the concept of boundaries is approached by counsellors and therapists. There are some other difficulties when investigating the influence of therapeutic traditions on boundary management. There are acknowledged to be over 300 types of counselling and psychotherapy recognised within the field (Feltham, 1995), and in reality there are likely to be many more. In addition, many therapists now work in an integrative style, which may involve the use of many different types of therapeutic influence. Therefore, exploring how a particular therapeutic orientation considers the concept of boundaries can be difficult when there may be difficulty in establishing from which orientation a practitioner derives. Furthermore, due to the vast expanse of therapeutic orientations an overarching

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classification of what are acceptable boundaries in therapy has been elusive (Gutheil & Gabbard, 2003). It is argued that any judgement made on a therapist's use of boundaries should take into consideration all contextual factors (Gutheil & Gabbard, 2003). Therefore, any attempt to correlate a counsellor's approach to boundaries with their therapeutic orientation is problematic and potentially very difficult to investigate.

Rigid versus Flexible Boundaries

Boundaries in counselling are often characterised as being "rigid or permeable" (McLeod, 2013, p422). This often results in a debate between those who propose rigid boundaries in therapy which, they argue, create greater safety for clients (e.g. Langs, 1990; Jacobs 2010) versus those who believe that counsellors should have a greater level of flexibility in implementing boundaries as part of a positive therapeutic encounter (e.g. Mearns and Thorne, 2013; Prever, 2010). This discussion of rigid versus flexible boundaries in counselling practice is still a very current debate in contemporary practice (Carey, 2016; Cobb, 2010; Devereux and Coe, 2010; Ingham, 2010; Jacobs, 2010; McLeod, 2013; Mearns and Thorne, 2013; Prever, 2010; Priestly, 2010; Proctor, 2014; Reeves, 2015; Ryan, 2010; Solomon, 2010; Totton, 2010).

There appear to be valid arguments on both sides of the debate. Those proposing a more flexible approach to boundaries argue that it enables a closer relationship to form with the client whilst also offering a more human experience (Carey, 2016; Mearns and Thorne, 2013; Totton, 2010). Indeed, Mearns and Thorne (2013) argue that the dominance of the very notion of boundaries as a concept in counselling could "suffocate the profession" (p23) if left unchallenged. Similarly, Totton (2010) argues that it is this concept which reduced human connection in the therapeutic encounter and recently Carey (2016) argues that that there are "[v]ery few therapeutic boundaries [that] need to be applied rigidly" (p296). Alternatively, those proposing rigid boundaries

argue that it creates not only safety and stability for the client but a clear structure for successful therapy (Devereux and Coe, 2010; Ingham, 2010; Jacobs, 2010). Reeves (2015) highlights the risk of inappropriate flexible (or uncertain) boundaries which may be well intentioned but offer inconsistency to the client for example the extension of time limits of sessions

Arguably, however the distinction between counsellors delivering either 'rigid' or 'flexible' boundaries is false because many therapeutic interventions needs both types of boundary to deliver effective therapy. This may be influenced by a variety of factors such as: what the client wishes to achieve in therapy (Priestly, 2010); the instincts of the counsellor (Cobb, 2010); or the context of the counselling sessions (Ryan, 2010).

For example, Worsley (2013) in *The Handbook of Person-Centred Psychotherapy and Counselling* advocates a firm set of professional boundaries to be in place to enable intimacy with a client to take place. This suggests a rigid boundary to ensure consistency and stability of the session whilst not placing barrier between counsellor and client. Worsley says "while professional boundaries remain in place, tenderness a sense of affection and even love (agape) can be felt and appropriately expressed" (p404). Similarly, clients from similar groups may need different types of boundaries depending on their own needs. For example, Prever (2010) argues that some children may require rigid and firm boundaries to build trust and feelings of safety with a counsellors whilst others may require more flexible boundaries so that their experience of counselling does not "replicate previous overly defined adult-child relationships" (p45).

Essentially, perhaps the discussion of rigid versus permeable boundaries is about the management of risk in counselling sessions (Proctor, 2014). Although Totton (2010)

warns that that the very notion of boundaries has pushed practitioners into 'defensive' practice, resulting in focusing on protecting themselves and not on the best interests of their clients. Solomon (2010) concurs with this view reporting that he will always work defensively (that is with rigid boundaries), despite any perceived benefit to the client to work otherwise, in order to protect himself from complaint.

As Reeves states "[t]he task for us as therapists … is to find ways of achieving a careful balance: to enable sufficient space and movement in the therapeutic relationship to allow for risk (for that is where important exploration may take place), while offering sufficient containment and boundaries to help ensure the risk is not overwhelming or a threat to either the client or the therapist" (2015, p5).

The discussion above highlights how the distinction between rigid versus flexible boundaries is often a false one because there are a multitude of ways that counsellors can approach boundaries in their practice. It might be useful then to move the discussion of boundaries away from whether they should be rigid/flexible and towards whether they have been made clear to the clients and the application of different types of boundaries is made transparent as part of the counselling process.

Discussion Point 5: An alternative view of boundaries?

This review of the literature above has detailed how ingrained the term 'boundary' is within the counselling literature. It has also highlighted how discussions of boundaries can centre on ethical decisions and can be greatly influenced by the theoretical approach of the counsellor. I have also highlighted how the argument of whether a counsellor should use rigid or flexible boundaries is a false one because counsellors are likely to approach and use many different types of boundaries in practice. It is important then to think critically when discussing boundaries. However, when doing

this it is clear that "we cannot simply dispense with boundaries but neither can our traditions stand still" (Feltham, 2010, p20).

Feltham (2010) questions whether certain 'boundary traditions' are fixed or whether with these can be questioned and adapted because of the passing of time and the profession having a greater awareness of cultural differences and multiple client perspectives. Other authors question whether the concept of boundary is even appropriate for the helping professions and offers alternative metaphors such as bridge, highway and territory (Austin, Bergum, Nuttgens, Peternelj-Taylor, 2006). The pluralistic approach to therapy attempts to offer an alternative view of the boundary concept that steps away from the traditional view of boundaries in counselling and psychotherapy as guided by the therapeutic tradition of the counsellor (Carey, 2016). The pluralistic approach to therapy is gathering a much greater dominance within the counselling field (e.g. Carey, 2016; Cooper, 2016; Cooper & McLeod, 2012, Cooper and Dryden, 2016; Gabriel, 2016a; Thompson & Cooper, 2012). The pluralistic approach to therapy "implies that there are a variety of views that can be taken on a wide range of therapeutic issues, and that there is no inherent right or wrong way" (Cooper and Dryden, 2016, p3). It has three main 'pillars' which are (1) pluralism across orientations; (2) pluralism across clients and (3) pluralism across perspectives. This effectively means that therapists are open to: different ways in which clients may become distressed and ways of helping them (pluralism across orientations); recognising diversity across clients (and therefore offering a bespoke approach) (pluralism across clients); both participants (clients and therapists) have a lot to offer when considering the goals, tasks and methods of any therapy process (pluralism across perspectives) (Cooper and Dryden, 2016).

The pluralistic approach also has its own approach to boundaries. This approach recognises therapeutic boundaries as essential and useful, but believe that they could be more nuanced than they are currently practiced within the profession (Carey, 2016). Carey states that "[b]oundaries should not be thought of in a limiting or restricting way but, rather, as guides to keep both therapists and clients safe, so the clients have the best chance possible of making the changes they seek in therapy" (Carey, 2016, p289).

Gabriel and Davies (2000) propose that the counsellor has a role of the 'boundary rider', that is, to establish and observe the relational boundaries in therapy. In this respect they can be referred to as the "sentinels of the process" (Gabriel, 2005, p59), and this means that their "cultural and moral values are significant features" (Gabriel, 2005, p60) when making decisions about boundaries. Dale (2016) states that "[e]very practitioner working within private practice will have developed their own individual way of working; each one therefore will want to create their own individual contract and set different boundaries in order to maintain the therapeutic framework" (p12). Even if a counsellor does not work in private practice they will still use their own approach to boundaries which will further be influenced by the organisational or contextual environment.

The pluralistic approach to boundaries has the following key points: pluralistic counselling is not 'boundary-less' but a flexible use of boundaries; the use of boundaries should support clients to 'get along' without the therapist; therapy is a resource for clients not a treatment applied to them; and different boundaries will be important for different clients (Carey, 2016). The pluralistic approach to boundaries (and indeed therapy) is relatively new to the counselling field. It is unclear what impact it will have on counsellors understanding and experience of boundaries within their

practice. Furthermore, there are relatively few courses which train students in this modality. However, despite this it has gained a great deal of traction in recent years within the counselling field. This approach to boundaries could almost be considered 'post-modern' as it aims to go beyond traditional views of boundaries and move away from the traditional modalities of therapy (Cooper, 2016).

Pluralistic boundary decision making

Gabriel (2016a) argues that the pluralistic therapist will build up a boundary 'tool kit' to support in the management of boundaries in their practice and directs readers to various resources. However, these resources are often about ethical decision making (Bond, 2015; Gabriel, 2005; Gabriel, 2009; Gabriel & Casemore, 2009). Carey (2016) proposes a set of questions to support with boundary decision making when using a pluralistic approach to therapy; questions he suggests are applicable specifically to a pluralistic approach (this table of questions is re-produced in *Appendix D, p326*). However, arguably many of the questions are applicable to counsellors from other modalities also. Carey does not distinguish between ethical and boundary decision making although other chapters of this book do focus purely on ethical decision making with reference to boundaries (Gabriel, 2016a). This suggests that these are considered two different (yet overlapping) aspects of practice. Carey's questions offer a pragmatic approach to boundary decision making. They consider elements of technique (e.g. what are my options? what was effective?) and ethics (e.g. what are the legal, professional and ethical implications of these?). However this model is not based on counsellors understanding and experience of boundaries.

Literature Review – Summary

In summary, this review of the literature has discussed the understandings and definitions of 'boundary'; with a review of the main discussion points in the literature.

These were: (1) Boundaries and Counselling Ethics; (2) Exploitation and Abuse; (3) Boundary Issues; (4) Types of Boundaries (5) An alternative view of boundaries?

It has been argued that the concept of 'boundary' is not clearly defined (Gutheil & Gabbard, 1993). Rather, within the literature multiple definitions being offered (Bond, 2015; Davies, 2007; Feltham, 2010; Gutheil and Brodsky, 2008; Proctor, 2014; Sarkar, 2004; Zur, 2010). The boundary concept is most often associated with the topic of counselling ethics and the limits of acceptable practice (Bond, 2015; Proctor, 2014). This is most often represented within ethical codes and frameworks (BACP, 2016a; COSCA, 2014; UKCP, 2009), and the concept has started to become much more dominant in the field despite a lack of clarity about what is necessarily being referred to. The protection of clients from exploitation and abuse is one of the main purposes of the boundary concept (BACP, 2016a; Bond, 2015; Proctor, 2014). Abuse and exploitation can be characterised as a violation of boundaries by the therapist to the client (Glass, 2003). However, although the extent of exploitation and abuse of clients by therapists is unclear (Halter, Brown and Stone, 2007) it is unlikely to represent the day to day experience of most clients. Therefore, purely focusing on this area when discussing boundaries can detract discussion away from how counsellors use boundaries in their day to day practice of counselling. The focus on abuse may also lead the focus away from counsellors who may neglect their clients for fear of their own vulnerabilities (Proctor, 2014) or lack of competency in various areas (Bond, 2015; Owens, Springwood and Wilson, 2012).

Boundary issues are an important aspect of practice (Proctor, 2014). Despite this there is difficulty in defining a 'boundary issue'. The term is often used to refer to an ethical dilemma (Reamer, 2001) although arguably it is often much more this, for example it can also refer to an aspect of therapeutic technique.

The terminology used in the literature can promote a notion of boundaries being purely related to ethics particularly through the notion of boundary transgressions because it infers a movement away from counselling norms and standards particularly with the terms 'violation' and 'crossing' becoming more prominent. A violation is a harmful breach (whether intentional or not) whereas a crossing is a neutral or possibly beneficial transgression (Gutheil and Gabbard, 1993; 2003). However, the criteria for defining each of these is still in flux. Gabriel (2005) suggests that it may be easier to consider any extensions to therapy work as either 'non-therapy or 'extra therapy' to distinguish their purpose. Extra therapy would be an extension of boundaries so as to advance the therapy whereas non-therapy would be an extension of boundaries that was not related to any therapy work. Although there may be justifiable reasons for extending boundaries in this way it adds another layer of reflection for the counsellor to consider why they are extending boundaries within the therapy sessions.

In practice boundaries can be split into many different types such as structural, interpersonal or intrapersonal boundaries (Brown & Stobart, 2008; Carey, 2016; Davies, 2007; Gray, 1994; Gutheil & Brodsky, 2008; Hermansson, 1997; Jacobs, 2010; Kent, 2013; Mearns and Thorne, 2013; Proctor, 2014; Sills, 2006; Smith, Collard, Nicholson and Bayne, 2012; Zur, 2010). Structural boundaries can be considered the outer limits of therapy which are the minimum requirements for therapy to occur and which hold it together (Davies, 2007; Gutheil & Brodsky, 2008; Zur, 2010), the outer framework if you will, the main examples are the contract and confidentiality. Interpersonal boundaries can be considered the boundaries which exist between counsellor and client (Davies, 2007; Gutheil & Brodsky, 2008; Zur, 2010) and are said to be informed by a variety of factors such as the therapist's therapeutic tradition (Jacobs, 2010; Mearns and Thorne, 2013), and the clients and counsellors own

identity and values (Gabriel, 2005; Gutheil and Brodsky, 2008; Hartmann, 1997; Ronnestad & Skovholt, 2003; Skovholt & Ronnestad, 1995). Whereas intrapersonal boundaries can be used to represent the psychological functioning of the self (Davies, 2007; Hermansson, 1997). Other boundaries may also possibly exist such as trans-personal boundaries which relate to spiritual and existential functioning.

The literature on boundaries has traditionally focused on whether rigid or flexible boundaries is more preferable in therapy (McLeod, 2013), which was often characterised as an argument between psychoanalytical and humanistic therapy (Jacobs, 2010; Kent, 2013; Mearns and Thorne, 2013). However, more recently authors have proposed a more reflective approach to boundary decision making suggesting that counsellors consider the risk and benefits of each application of boundaries individually (Carey, 2016). This is further supported by the advancement of pluralistic counselling within the counselling literature (Cooper and Dryden, 2016; Gabriel, 2016a).

Finally, there are no practical models that exist to support counsellors in making boundary related decisions in their practice; nor are there any models that are based on counsellors' understanding and experience of boundaries. Certainly, there are ethical decision making models available (e.g. Bond, 2015; Davies, 2015; Gabriel, 2016a; Pope & Vasquez, 2016; Proctor, 2014). However, their focus is often on tackling larger ethical dilemmas or areas of complicated ethical reasoning rather than issues of therapeutic technique or even smaller ethical issues. Furthermore, these models require practitioners to 'go away' from counselling sessions and reflect on specific incidents before identifying an appropriate approach to the issue, which is not useful for making immediate decisions whilst in a counselling session.

The pluralistic approach to therapy (Carey, 2016) proposes a new approach to boundaries which acknowledges the benefits of therapeutic boundaries whilst arguing for a more nuanced approach than is currently advocated within the profession.

Finally, there is limited research which considers how counsellors understand and experience boundaries within their practice. Furthermore, despite the advancement of this more reflective approach to boundaries there still does not exist a practical model which supports counsellors to make boundary related decisions within their practice that is based in actual counsellors understanding and experience.

The literature review has highlighted that: the concept of boundary is broad but often left undefined; it often relates to ethical practice but can also relate to therapeutic practice; there is limited research into therapists understanding and experience of boundary; even though the concept often relates to therapists experience of therapy. I have argued that there is a need to comprehend how counsellors understand and experience boundaries so as to better inform training programmes; to consider the role of boundaries in the future of counselling theory and practice; and to protect clients and counsellors. These reasons have contributed towards determining the methodology and method which has been used within this research. The following chapter will therefore explore the rationale for deciding on these approaches whilst reflecting on their suitability for exploring counsellors understanding and experience of boundaries. It will also detail the methodology for this study.

<u>Chapter Three – Research Methodology</u>

The second aim of this thesis was: **To explore how counsellors understand and experience the concept of 'boundary' in their practice.** So, this chapter details how I approached this aim through a detailed description of the methodology used. This includes the ontological and epistemological assumptions of the research. This study was approached from a critical realist perspective with epistemological underpinnings of phenomenology, hermeneutics and idiography.

This chapter will then describe methodological issues such as: the method of data collection; sampling; ethical considerations; and the process of gathering the data for this study. The analytical process is then described in detail. Multiple qualitative methods of data analysis were used. An initial analysis used Interpretative Phenomenological Analysis (IPA). This analysis was felt insufficient to represent participants' accounts fully therefore further analysis was completed using other qualitative analysis methods such as pen portraits.

The search for validity and reliability is also detailed including reflexivity of the researcher to ensure that the findings of this study were trustworthy.

<u>Ontology/Epistemology</u>

This study is approached from a critical realist perspective. Maxwell (2012) defines this as ontological realism combined with epistemological constructivism, and suggests it was first purported by Donald Campbell in 1957. Critical realism, according to Maxwell, suggests that the world is real but not objectively knowable. That is, there is a real world outside of our independent thoughts, perceptions and constructions. However, our understanding of this world comes from our own perspective and standpoint. Furthermore, critical realists argue that even though our mental states and

attributes are not directly observable, they are part of the real world. This is in contrast to positivism which argues that they cannot be real, and constructivism which suggests that they only exist as a perspective (i.e. they are not a part of reality).

This research uses an interpretivist epistemology. This attempts to understand and explain human and social reality (Crotty, 2010), by interpreting the subjects perceptions (Denzin & Lincoln, 2011) and therefore illuminating hidden aspects of human experience. The concept of 'boundary' in counselling is both ambiguous and open to interpretation (Gutheil & Gabbard, 1993). Therefore, an exploration of how practitioners perceive and use this concept is useful.

Qualitative enquiry was used for this study because it was the most appropriate for investigating the knowledge and experience of counsellors i.e. listening to stories about therapy (McLeod, 2008). Qualitative enquiry was used in this study because it can gather an 'inside' perspective from previously under researched areas (Finlay, 2011); it is useful when pursuing topics of potential sensitivity or emotional depth (Wolgemuth, Erdil-Moody, Opsal, Cross, Kaanta, Dickmann, & Colomer, 2015); and it can capture the lived experience of participants as well as the meaning behind it (McLeod, 2008).

Crotty (2010) identifies that ontology and epistemology are so intertwined that it is difficult to examine one without the other. The epistemological underpinnings of this research are informed from three main areas: phenomenology, hermeneutics and idiography.

Phenomenology is both a philosophical school of thought and an approach to research. Its focus is on understanding the human experience – particularly in the *lived world.* Sullivan (2011) states that "its basic aim is to describe and interpret people's

perspectives and perceptions and examine how they are related to their experience of the world around them" (p31). Therefore, it is a useful approach for examining counsellors' lived experience of 'boundaries'.

Hermeneutics is a theory of interpretation, and also informs this research process. Hermeneutics is a philosophical underpinning to the interpretation of text (originally biblical), although it is now applied to unwritten sources such as human practices and events (Crotty, 2010).

An extension of hermeneutics by Heidegger is phenomenological hermeneutics. In this theory Heidegger argues that meaning can be revealed from phenomena (such as text) through interpretation, whilst understanding that the very nature of the phenomena or the interpreter may mean that any such meaning is concealed. This relationship between the researcher and the data is a non-linear conceptualisation of research (i.e. insights are not arrived at by a simple reading of the text but a relationship with it). It is often referred to as the 'hermeneutic circle'. It highlights the relationship that exists between the 'part' and the 'whole'. Smith, Flowers, and Larkin (2009) state "to understand any given part, you look to the whole; to understand the whole, you look to the parts" (p28).

In terms of this research it is useful for highlighting the complex interconnected relationships that exist within the research process, for example the relationship between the researcher and the data; the researcher and the participants; or between the participants/researcher and the counselling profession. The hermeneutic circle identifies that each of these elements cannot be examined from purely one point of objectivity and that research can be understood from multiple perspectives. Smith, Flower and Larkin (2009) state that "as one moves back and forth through this process,

it may be helpful to think of one's relationship to the data as shifting according to the hermeneutic circle, too. The idea that our entry into the meaning of a text can be made at a number of different levels, all of which relate to one another, and many of which will offer different perspectives on the part-whole coherence of the text" (p28). This approach suggests a level of flexibility and reflexivity towards data analysis whilst also encouraging the researcher to have a level of awareness around their role in the process, and any preconceptions they may have. This is particularly useful in this study because of the in depth nature of the inquiry (i.e. the small sample size). Furthermore, the complex nature of the concept of 'boundary' meant that flexibility in completing the analysis was important to ensure that new insights were accurate and representative of participants and that the researcher was able to acknowledge their role in these interpretations.

So then, a combination of both a phenomenological and hermeneutics approach was used so that the 'essence' of the phenomena being investigated (i.e. the concept of 'boundary') could be both described and interpreted.

Finally, another influence on this research epistemology is that of idiography, i.e. a focus on the particular rather than the general. Smith, Flowers and Larkin (2009) suggest that this is useful for two reasons. First, there is a focus on a much deeper level of detail than can be gathered through a nomothetic study. Second, there is a focus on understanding 'particular experiential phenomena' from the view point of individual people, within a specific context. Therefore, this research used only a small group of participants however the data collected was examined at a significantly deeper level.   An examination of the analytical methodology used is discussed later in this chapter. However, it is important to note here that this study initially used Interpretative Phenomenological Analysis (IPA) for this endeavour and the selection

of this approach has also influenced other aspects of this study such as the sample size. This is therefore discussed throughout this chapter. IPA has its "theoretical roots in phenomenology, hermeneutics and idiography" (Smith, 2011a, p9).

Determining the Data Collection tool

The identification of the most appropriate data collection tool was important to elicit the richest possible data with regard to the aims and objectives of this research. This led me to consider which data collection tool was most useful in relation to the following factors: its suitability with the phenomenological underpinnings of this research; its appropriateness for counselling and psychotherapy research; its suitability to be used in conjunction with a critical realist approach to research; its ability to elicit detailed life world experiences of counsellors; and its value in exploring the concept of 'boundary'. These considerations led to the decision that semi-structured interviews were the most appropriate tool for collecting data for this study.

The three main data collection methods used within phenomenological research (although there are others) are interviews, participant observation and written accounts (Finlay, 2011). Participant observation was not appropriate because this study wanted to focus on counsellors' personal experience and the meaning of this for participants. Therefore, this was quickly ruled out as a data collection tool. Written accounts were seriously considered as a data collection tool. However, the difficulty would be in how these would be generated. It is unlikely that participants would already have written accounts of their experience of boundaries, unless the study asked to examine participants' notes from their counselling sessions, this was not deemed appropriate. Requesting a specific written account from participants was considered, for example via email. However, it was felt that participants would be limited in what they could explore in such a text. It was felt that a written account would be less likely,

than say an interview, to produce rich and varied data, because of the inability of the researcher to explore areas of interest without asking participants to answer further questions. Focus groups were also briefly considered. However, these were also dismissed because of the likelihood that discussions in focus groups can centre on participants evaluating topics (i.e. expressing their attitudes and opinions) and therefore losing the phenomenological focus of the study (Smith, Flowers & Larkin, 2009).

Interviews, however, can be considered a flexible data collection tool. Kvale (1996) lists the main elements of a qualitative research interview, and I use them here to draw attention to the benefits of using interviews for this study. Kvale identifies that qualitative interviews should: focus on the participants life-world; focus on meaning as well as experience; be qualitative and descriptive; focus on specificity (i.e. particular situations and actions); allow the researcher to approach the interview with openness (i.e. no pre-conceived ideas or categories); be focused (i.e. a balance between set questions and a freedom to express dialogue outside of the set frame); expect interview statements to be ambiguous; expect participants to change their perspective during or because of the interview; mean different interviewers may produce different material; be an interpersonal experience between two people; encourage a positive experience for both researcher and participant because of the common interest in the interview theme.

From a critical realist perspective interviews (and other qualitative data collection tools) are useful for examining the real processes and procedures (including mental processes and procedures) that are not directly observable (Maxwell, 2012). This study aims to explore these processes and procedures in relation to the practitioners experience and understanding of boundaries. Maxwell (2012) states that "(t)he main

implication of realism for qualitative data collection is that data are usefully seen, not simply as "texts" to be interpreted, or as the "constructions" of participants (although they are this), but as *evidence* for real phenomena and processes" (p103) [italics as original author intended].

Clearly, interviews in phenomenological research can be considered to have a natural affinity with counselling and psychotherapy. Both involve a dialogue between two people, one person helping to facilitate the others exploration of personal experiences and the meaning attached to them. Openness, empathy and active listening are key components to phenomenological research both when engaging with participants and the data (Finlay, 2011). These, of course, mirror the core conditions of person-centred counselling (and arguably all therapeutic encounters), that is empathy, congruence and unconditional positive regard (Rogers, 1957).

Researchers who are also therapists (as is this researcher) are already trained to listen and help others express themselves and therefore have an advantage when completing research interviews (Finlay. 2011). However, similarly to counselling and psychotherapy there is a large power differential between the researcher and the participant (McLeod, 2008), just as there is between a counsellor and a client (Proctor, 2002). Therefore, Finlay (2011) argues that therapist skills used in research interviewing can easily lead a participant into emotional disclosures beyond the remit of the research itself. In this respect it was important for me to focus on the research question during the interview this may mean refocusing a participant back to the topic for example if their discussions had veered significantly away from discussing boundaries. This could have potentially been very challenging as I was aware that the pertinence of any discussion may only be realised through the analysis of the interviews. Therefore, I did not want to stop potentially useful insights appearing

therefore I attempted to allow free expression from the participants unless they wandered into areas of distress or upset (which none of them did). Similar ethical approaches guide both the counselling and research processes which was useful if any questions came from participants. Furthermore, because of their role as counsellors participants were already familiar with the dialogical approach that interviews encourage which meant they were less likely to make disclosures that they would later regret.

Semi-structured interviews are the most usual form of data collection for studies which employ IPA as their method of data analysis (Brocki and Wearden, 2006). Furthermore, "the advantage of semi-structured interviewing for IPA is that the researcher is, in real-time, in a position to follow up interesting and important issues that come up during the interview" (Smith, 2004, p50).

There are some disadvantages to using interviews (McLeod, 2008, 2010). Interviews can take time to set up, complete and transcribe. The transcribing of the interviews was one of the most time consuming aspects of this study and although there was a consideration in the planning stages of this thesis to ask a third party to transcribe these recordings I felt that transcribing them myself would enable me to have a closer relationship with the accounts and enable more detailed insights for the study. The recording of interviews can be intimidating for participants (I have detailed later the impact of the recording device on these interviews). The quality of the information received in interviews also depends on the level of rapport that is built up between the researcher and the participant. Therefore, I attempted to build rapport with participants before the beginning of recording the interviews. Participants' answers may also be influenced by the role of the researcher as an authoritative expert on the theme of the interview. However, although it is acknowledged that participant and researcher are

both active partners in the interview process, it is assumed that the interview discussion will be led by the participants' views and thoughts – i.e. "the participant is the experiential expert on the topic in hand" (Smith, Flowers, Larkin, 2009, p58).

Overall, however, it was considered that interviews were the most appropriate data collection tool for this study because they can facilitate the exploration of stories, thoughts and feelings about individual phenomenon (Smith, Flowers & Larkin, 2009) in this case the concept of 'boundary'. Interviews are synonymous with exploring personal experience and meaning. Interviews offer a level of flexibility, particularly in terms of allowing participants to speak freely and reflexively, allowing them to tell their stories, and express themselves thoroughly which other data collection tools can sometimes inhibit. Furthermore, interviews can produce data that is detailed and rich, particularly if they are allowed to be fluid and spontaneous (Finlay, 2011, p199).

Sampling

Purposive Sample

IPA sampling tends to be purposive. In IPA the goal is "to select participants in order to illuminate a particular research question, and to develop a full and interesting interpretation of the data" (Brocki and Wearden, 2006, p95). The topic for investigation in this study was the understanding and experience of counsellors of the concept of boundary. This research wanted to look at how counsellors understand and experience boundaries in their day to day practice. Therefore, participants did not need to have any particularly strong views or experiences related to boundaries or boundary issues to qualify for this study. Therefore, participants in this study were chosen because they were qualified and practicing counsellors. As such, a purposive sample was used. Due to the small number of proposed participants and the broad selection criteria the participants were selected from the researcher's current professional and

personal networks of UK counsellors. Only one participant was known to the researcher in another capacity (the potential impact of this will be detailed later).

Sample Size

An initial sample size of 9 participants was estimated at the early stages of the research process (although eventually 7 participants were interviewed). This decision was influenced by discussions on sampling set out in the book - *Interpretative Phenomenological Analysis: Theory, Method and Research* by Smith, Flowers and Larkin (2009), the researcher's own previous experience of IPA research at undergraduate and Master's degree level and other IPA studies (e.g. Avis, 2010; McGreevy, 2010). However, this researcher was highly aware during the whole of the research process that "[s]ample size is an abstract idea that can only be put into practice through some process of gaining access to informants or subjects" (McLeod, 2008, p31).

Smith, Flowers and Larkin state that there is no 'right answer' when considering the issue of sample size in an IPA study. However, IPA is tasked with exploring a detailed account of individual experience. Therefore, they suggest that more problems are likely to arise with a sample size that is too large rather than one that is too small; quality is valued here rather than quantity. So, IPA projects are more likely to profit "from a concentrated focus on a small number of cases" (Smith, Flowers, and Larkin, 2009, p51).

Brocki and Wearden (2006) found that IPA studies used between 1 and 30 participants per study. Whereas Smith et al (2009) identify between 3-6 participants as a sufficient number for student projects, and suggest that many experienced IPA researchers are also using these samples sizes. However, they also argue that each study is different

and will depend on the research question and quality of the data obtained. This suggests that sample size cannot be fully determined at the start of a study, and has to be reviewed as interviews and analysis are completed. 9 participants were deemed appropriate at the beginning of this study which aimed to interview 7 female and 2 male counsellors (in line with the approximate ratio of male/female counsellors in the UK - BACP, 2014). This number was reduced to 7 participants (6 female and 1 male) as the data retrieved was so rich that it was deemed more useful to focus on the data gathered rather than collate anything additional.

Smith et al (2009) also argue that sample size will be influenced by the level of dedication the researcher has towards the analysis and reporting of IPA at the case study level. Personally, I have completed IPA studies at the undergraduate and Master's degree level of study and I am aware of the level of undertaking that is needed to analyse and interpret data using IPA. However, I am also aware that this can be highly influenced by the richness of the data that is provided by participants. I chose at a relatively early stage of the data analysis phase that I wanted to focus and commit to exploring and representing the accounts of the participants I had already interviewed. Focusing on the current participants rather than introducing new ones meant I did not limit any further analysis with the potential of losing some of the richness and depth of participants' accounts.

Finally, it was considered whether 7 participants was sufficient for a PhD level study. However, there are other PhD research studies which have been completed with less than 10 participants (for example see Avis, 2010; McGreevy 2010; Oakley 2009). All these projects explored sensitive material in great depth. In common with these completed PhD research studies, this current study explores a sensitive issue in much depth.

Homogeneous Sampling

Another common element of an IPA study is that it is carried out with homogeneous groups. That is a group of participants that are alike or share particular characteristics. Most IPA studies aim to adopt small, homogeneous groups for their sample (Smith, Flowers, and Larkin, 2009).

To establish homogeneity many studies apply specific criteria to their sampling. For example, Porter, Hulbert-Williams and Chadwick (2015) in their study of sexuality in the therapeutic relationship required participants to be: male; identify as gay or homosexual; be either accredited counselling psychologists, clinical psychologists, counsellors, psychotherapists, or counselling psychologists in training; had experience of working therapeutically with heterosexual clients; or had experience of working therapeutically with Lesbian, Gay, Bisexual, Trans or Queer (LGBTQ) clients. Therefore, this sample had multiple features to assist in finding a homogeneous sample.

Brocki and Wearden (2006) found that the majority of IPA studies did not attempt to achieve a representative sample of the population they were studying or a sample that was likely to be representative. For example, the participants in Porter et al's (2015) study varied greatly in their age, ethnicity and the amount of years they had been practicing. Indeed, due to the small sample sizes used within IPA findings are unlikely to be generalizable across populations because the focus of IPA is on the detail of the lived experience of participants rather than aiming to assess the similarity of accounts across populations (Smith et al, 2009).

Despite IPA not aiming for generalisability there is still a need for selective criteria for an IPA study, so that the research being conducted is based within an appropriate and

relevant population of participants (Smith et al, 2009). Therefore, the criteria enlisted to establish homogeneity, in this study, was for participants to be both qualified and practicing counsellors. Arguably, these criteria approach homogeneity from a much broader base in comparison to most IPA studies. However, selection on this basis was felt to best illuminate common elements to the concept of 'boundary'. Other IPA studies within counselling and therapy research have used broad based criteria for the selection of participants. For example Daw and Joseph (2007) used IPA to explore the experiences of personal therapy among qualified therapists.

Initially, selection of participants was going to include the participants' therapeutic tradition as part of the selection criteria (e.g. participants had to be person-centred counsellors). However, this was eventually decided against, due to the complexity of establishing the therapeutic tradition of individual counsellors. For example, participants often had been trained in one therapy but used techniques or approaches from many others. Therefore, using this as selection criteria was often unhelpful. Furthermore, other IPA studies have also included participants from multiple theoretical backgrounds when looking at concepts which span across (rather than are specific to) therapeutic traditions. For example, McGown (2015) explored the therapist's spontaneous mental imagery and its impact on therapeutic process using therapists from multiple backgrounds. Similarly, this study is looking at a concept which transcends therapeutic traditions – 'boundaries', and therefore did not eventually specify the counsellors' tradition as selection criteria. Therefore, the participants' selection criteria for this study is in line with other IPA studies within the field. (Please see table below for details of participants).

Participant	Gender	Age	Ethnicity	Tradition	Role	Other	Years Qualified
A	**Female**	**40'S**	**White**	**PCA**	**NHS**	**Grief/Nurse**	**5+**
B	**Female**	**40'S**	**White**	**PCA**	**Priv/GP**	**.**	**5+**
C	**Female**	**40'S**	**White**	**PSYCH**	**Priv.**	**.**	**10+**
D	**Male**	**60'S**	**White**	**PCA**	**Priv/Vol**	**Alcohol/Grief/Supervisor**	**10+**
E	**Female**	**50'S**	**White**	**Integ.**	**Vol/Uni**	**Domestic Viol/Students**	**<1**
F	**Female**	**55-65**	**Black**	**PCA**	**Priv/GP**	**Lecturer**	**20+**
G	**Female**	**50'S**	**White**	**PCA**	**GP/Coll.**	**Tutor**	**10+**

Table 1: Demographic Details of Research Participants

KEY: PCA=Person-centred approach, PSCH=Psychodynamic, Integ=Integrative, Priv=Private Practice, GP=Doctors surgery, Vol=Voluntary agency, Uni-University counsellor, Coll=College counsellor

Ethics

This research adhered to both the British Psychological Society Code of Human Research Ethics (BPS, 2010) and the BACP Ethical guidelines for researching counselling and psychotherapy (Bond, 2004). This project was also approved by the Manchester Metropolitan University Ethics Board at the initial stage of this thesis in 2010.

A discussion of ethical considerations and how they were addressed within this research project are detailed below.

Consent

Consent, or to be more specific – informed consent is a priority of psychological (BPS, 2010) and counselling research (Bond, 2004). Informed consent should ensure participants have a full understanding of the research purpose, how the information will be used and their rights to privacy, safety and confidentiality' (Abrahams, 2007, p241). Good practice in counselling research requires the following: participants in

research are sufficiently informed and give their whole and unrestricted consent before the research takes place; researchers are culturally sensitive to any areas which may impact on participants ability to consent fully; participants are provided with a statement of the research aims before consenting to the research; participants are made aware of the research process and care is taken towards those who cannot consent for themselves (Bond, 2004).

In this study: all participants were provided with an information sheet before agreeing to complete the study (see *Appendix E, p328*). Furthermore, this information was provided by email at least a few days before each interview which enabled participants to read it fully and ask questions before they completed the study. Participants then completed and signed an informed consent form (see *Appendix F, p330*). My contact details were also provided to enable any questions to be asked, as well as other opportunities (such as the minutes preceding the interview). Details were also provided of my thesis supervisor if participants did not want to direct questions to myself. There was no 'reward' offered to participants except the opportunity to be part of and inform counselling research. Throughout all communication, including email, consent documents and verbal discussions participants were made aware that they were under no obligation to take part in the study. All participants were qualified and practicing counsellors and were able to consent to taking part. Participants were made aware of the research process, including the analysis of their interviews.

<u>Deception</u>

There was no deception involved in the research conducted. All participants were made of the research process from the outset, including the publication of this thesis, or smaller research papers. Participants were made aware that quotations from their

interviews would be used in these publications. My own role as a counsellor and researcher was made clear to the participants at the outset of the research process.

Withdrawal

Good practice in counselling research ensures that participants have a right to withdraw their consent at each stage of the research process (or modify it) (Bond, 2004). Furthermore, their right to withdraw, which can be at any time of the research process, should be without penalty (BPS, 2010).

Participants of this study were made aware of their right to withdraw from the study at any stage, this was highlighted in the information sheet provided as well as through general reminders (e.g. before and after the interviews took place). None of the participants withdrew from this study.

Confidentiality and Anonymity

Good practice for counselling and psychotherapy research with regards to confidentiality and anonymity dictates that the standards and protection for confidentiality should have similar levels of protection as the therapy itself (Bond, 2004). However, the confidentiality offered to clients is often absolute (except for legal or supervisory requirements). Therefore the confidentiality offered to research participants cannot have the same level of protection (particularly of qualitative research as one aim is that the voice of the participants is often shared with the wider public). Certainly what can be offered to participants is anonymity in the research process. However, even this needs to be considered thoroughly as any revelation of their details may make participants identifiable within a research study. This is particularly true in IPA studies when more details of participants are likely to be revealed because of the in depth focus of individual accounts.

For participants in this study their details remained confidential at all times (and remained known to the researcher only). Participants were informed that although accounts would not be confidential they would be anonymous. This anonymity included the removal of any identifiable features. This was problematic when reporting and analysing one of the participants accounts as they had had in the past another relationship with the researcher. This relationship impacted upon the data gathered, it was therefore difficult to analyse without further personal reflexivity, the details of which could not be fully shared within this paper for risk of identifying the participant. This was managed through personal reflections and discussions with my supervisory team to ensure I was representing accounts fairly whilst also maintaining confidentiality. Despite this difficulty the anonymity of this participant is paramount and therefore comes before the need to detail the findings of this study.

Best practice in counselling research also dictates that researchers uphold current requirements for data protection (including legal requirements such as the Data Protection Act, 1998) (Bond, 2004). Therefore, all records of participants' details were password protected and held safely by the researcher. Participants were not identified even in early versions of this thesis.

Best practice also dictates that researchers be aware of any conflicting areas of confidentiality and ensuring that they adhere to any promises made to participants (Bond, 2004). However, there were no additional issues raised in terms of confidentiality or anonymity than those reported here.

<u>Power</u>

Ethical research ensures an approach which "regards people not as objects to be researched, but as human beings possessing their own power, who can be regarded

as equals and collaborators in the research process" (Abrahams, 2007, p243). The very use of the term 'participant' should serve to highlight the autonomy and agency of each individual who offers to take part in a research project (BPS, 2010).

The inherent power in my role as researcher was apparent to me from the start of this study. I was acutely aware of the parallels of power between my role as a counsellor compared to the client, and my role as researcher compared to the participant. McVey, Lees and Nolan (2015) suggest that being a practitioner-researcher (that is someone who is a counsellor/therapist but also uses those skills within their research) can have numerous benefits, such as: opening up access to the 'relational space' (which is filled with memory and emotion) and therefore expanding the scope of the research process itself. This, they argues, enriches the research process. Bond (2004) states that good practice in counselling research means that the research relationships should be consistent with the type of research being completed. However, there is a fine line between the use of counselling or therapeutic skills in counselling research and that of actually completing a therapy session.

Many skills or qualities are transferable between counselling and qualitative research such as empathy, positive regard etc (McLeod, 2008). However, the aim of each of these encounters is different (Dickson-Swift, James, Kippen and Liamputtong, 2006). Research aims to elucidate information from a participant (McLeod, 2008) whereas therapy is aiming for change for the client (McLeod, 2013). Authors have highlighted how there can be a struggle with boundary issues when being both a researcher and a therapist (e.g. Etherington, 1996; Dickson-Swift et al, 2006). Dickson-Swift et al (2006) suggest that research interviews can 'mirror' counselling interviews and this can result in conflict between the researcher's attempts to build rapport with participants and their need to have detachment as part of the research process. In

contrast, Etherington (1996) expresses how she experienced glee at the gathering of such rich data from a participant to only then experience guilt at feeling such positive feelings, particularly when the data was such a painful and personal story from the participant.

Wolgemuth, Erdil-Moody, Opsal, Cross et al (2015) found that participants of their qualitative research studies highlighted concerns about being identified; how they would be represented in the research; the potential for problems to be caused for themselves or others because of the interviews and the potential to experience emotional pain. Therefore, researchers need to be aware of any areas of vulnerability of participants and act appropriately and sensitively (Bond, 2004). Researchers also need to ensure that their relationships are responsive to ethical challenges and be aware of the risks to people (Bond, 2004).

In my role as researcher I was aware that it was important to reflect on my position of power within the research process. Ethical reflexivity was therefore an integral part of the research process and also facilitated some very significant changes to the direction of this study (I will detail these later in the study). I was aware of the need to go beyond descriptive accounts of the participants' interviews to offer depth and richness to the findings. The chosen methodology (i.e. IPA) offered a way of doing this through my own interpretation of the accounts. However, it also ran the risk of inflicting my own bias onto the participants' accounts. It was only through the depth of reflexivity throughout this study that I was able to minimise this as much as possible. This is detailed throughout this study.

Publication

Good practice dictates that in counselling research all reports should be: fair and honest; effective communication with the intended audience; give consideration to communicating the final research to participants; and the vulnerability of research participants when their interviews are published (Bond, 2004). Participants were asked for consent: to record, transcribe and analyse their accounts; to use quotes from their interviews in the final thesis and any subsequent research paper(s).

The impact on participants when they read the researchers interpretation and analysis of their interviews was fully considered whilst writing this thesis. Hoskins and Stoltz (2005) highlight the 'fear of offending' participants when completing qualitative researcher, particularly when it has an interpretative element to it. Indeed reflection on this point directed some of the later analysis of the interviews in a different direction and is discussed later in the *Findings* sections. It is important to consider the publication of any research findings and how this impacts on the many relationships involved with the research process, i.e. the researcher and the participants, the researcher and study supervisors and the researcher and the reader. As Parker (2005) puts it "the task is not to avoid these problems but to be aware of how they will always structure the way a report is written, who it will please and why" (p150).

Gathering the data

Interview schedule

There are very few IPA studies which fully detail the research process particularly the research schedule or list the prompt questions used (Brocki and Wearden, 2006). This can be problematic because it can make it difficult for readers to assess the appropriateness of the questions researched and the approach that the researcher has taken with their questions. The interview prompts for this study can be accessed

in *Appendix G, p331*. These questions/prompts were designed to be open ended questions which focused on the participants understanding and experience of boundaries in their counselling practice. The researcher attempted to stick to these prompts throughout each interview and only ventured further questions if the participant needed further prompting or if an area of particular interest had arisen which necessitated further questions. Prompts were designed to be non-leading (i.e. without a bias from the researcher). Readers can judge for themselves the appropriateness of these prompts.

Interviews

Each participant was interviewed on the subject of 'boundary' in their counselling practice. There was no set timescale for the interviews (they were deemed to take as long as needed), but a rough estimate of one hour per participant was suggested in the information sheets. Before each interview the researcher spent approximately 15 minutes chatting to the participant about themselves and their counselling background. In retrospect I think it would have been useful to start recording the interview from this point rather than the start of the research questions because the turning on of the recording device created a change of mood with some of the participants (i.e. they went from friendly and relaxed to slightly tense and awkward). Caronia (2015) highlights how recording participants and the use of a recording device within research is likely to influence participants in their research interviews and this is often evidenced by participants mentioning the device either before, during or after the interview. Certainly, some of the participants in this study did refer to the recording device in the interviews. One participant warned me to stop speaking casually at the end of an interview so as not to record my comments about the interview. The same participant also commented on how the atmosphere had changed when the recording device had

been turned on. Another participant made a statement 'for the tape' as they put it, as if it was particularly important that that statement was recorded. The other participants did not mention the recording device. However, Caronia (2015) argues that it will always influence the interviews to some degree whether participants mention it or not. Caronia (2015) also argues that despite no evidence to support this argument researchers often state that participants forget that they are being recorded to suggest that it has limited influence on the research process. It is unclear to what degree of influence the recording device had on this study although the comments from participants indicated to me that it did have some impact both in terms of anxiety about what was being recorded for some whilst also being a tool of public expression for others. Despite these difficulties with using a recording device I feel that it was the right decision to record these interviews because of what would have been lost if this had not been done. The recordings had to be listened to on multiple occasions to ensure the accuracy of the accounts was detailed (which would have been impossible without recording). Arguably, participants may have been just as anxious completing interviews without the recording device.

Upon completion of each interview the recording was transcribed verbatim and then analysed.

<u>Analytical Process</u>

The analytical process for this study is complex. Although the analysis of the participant transcriptions can broadly be described as using the method of IPA set out by Smith, Flowers and Larkin (2009) as a researcher I found this process restrictive in terms of both representing participants accounts and exploring them. This is because of the need in IPA to reduce the accounts into superordinate themes. This process felt too reductive to me and meant some of the nuanced aspects of the participant

accounts was becoming lost. Therefore, I also used other qualitative research methods to analyse and interpret the data gathered. Completing a 'super' audit trail that recounts the actual decisions of a qualitative research project rather than the idealised version often portrayed in research studies can offer a greater opportunity for readers to assess the trustworthiness of a study (Rolfe, 2006). Vice versa - writing a summary of the analytical process can risk diluting the complexity and challenges that occurred in reality. Furthermore, it does little to explore the route through which the analytical process occurred. Therefore, I have chosen to examine the research process of this study here in some detail. I have set this out in terms of a temporal approach, that is, from the start of the research process to the end. This best reflects the meandering route and the non-linear process through which I passed – it is also a more 'honest' account of how I came to the conclusions I have, and therefore enables the reader to better assess the reliability of these findings (Rolfe, 2006).

IPA Analysis

The interview transcripts were initially analysed using Interpretative Phenomenological Analysis (IPA). IPA studies are most commonly associated with the area of psychology although it is also used by other research fields (Carrera-Fernandez, Guardia-Olmos and Pero-Cebollero, 2014). The aim of IPA is to explore phenomena (such as activities, emotions and concepts) from the perspective of the participant (Smith, 1996), that is their - 'lifeworld'. However, it is acknowledged that a researcher cannot do this directly (unless considering their own experience) or fully without the influence of their own experience and conceptions (Smith, 1996). Larkin, Watts and Clifton (2006) describes IPA as having three core concepts: (1) the phenomenological component maps out the participants concerns and cares; (2) the interpretative component contextualises these and then considers how each participant makes

sense of them; (3) finally this will deliver a renewed insight (that is gained from the phenomena being investigated). It is this insight that services as a contribution to knowledge.

Benefits and Difficulties of IPA

IPA is therefore useful in considering counsellors' understanding and experience of boundaries within their practice as it enables the researcher to consider the lifeworld of participants whilst also enabling the researchers own experience and conceptualisation of boundaries to be considered and contribute towards the analysis of the participant interviews.

Parker (2005) highlights some difficulties with IPA such as: there can be an overzealous search for meaning and intention by researchers into participants accounts which is not actually there for participants; researchers show naïve realism – that is accepting interviews at face value rather than delving deeper; and an over reduction to the individual (i.e. not taking into consideration the circumstances or context which has impacted upon the construction of the 'inside perspective'). Within this study the reflexive elements of this study have aimed to report participants' accounts fairly and accurately and has been aware of the need to be careful with interpretations made. Indeed some interpretations were changed upon later reflection and analysis (see details in the Findings sections). The researcher aimed to delve beyond the literal accounts and meanings given by participants and this has resulted in the proposed models in this study. Finally, the interpretation and analysis of these participants' accounts cannot be understood outside of the context and circumstances within which they live. Indeed the impact of the individuals own circumstances upon their understanding and experience of boundaries is highlighted as one of the more interesting findings of this study.

Discounted Alternative Methods of Analysis

The use of IPA was considered the most appropriate analytical tool for analysing these interviews. However, other analytical methods were considered. Discourse analysis was considered as one way of analysing the participant interviews. Discourse analysis "examines the detail of talk and interaction to explore the consequences of constructing reality in particular ways" (Wiggens and Riley, 2011, p153). Discourse is analysis is useful in questioning common sense or typical understandings of the world around us and how these are used in interactions between individuals (Wiggens and Riley, 2011). Discourse analysis "can provide a positive social psychological critique of any phenomenon under the gaze of the researcher" (Morgan, 2010, p4) which may have been useful in exploring the concept of 'boundary'. However, this research aimed to explore the lived experience of counsellors regarding their concept of boundary rather than how they constructed this concept in discourse. Furthermore, discourse analysis is not concerned with causality i.e. why participants may construct meanings in a certain way (Wiggens and Riley, 2011); whereas this research was interested in the causality of participants' boundary use in their practice. Other difficulties with discourse analysis include: there are various forms of discourse analysis with their own epistemological positions and techniques; meaning os often never 'fixed' which leaves it open to constant interpretation; there can be confusion over concepts either because of their similarity or difference for even experienced researchers; analysis can be disturbing for participants because it can challenge established concepts such as selfhood, gender and identity (Morgan, 2010).

Another type of analysis that was discounted was that of grounded theory. Grounded theory is the generation of theory from the data through analytical enquiry which takes a cyclical form (i.e. the researcher goes back and forth with the data and analysis) (Gordon-Finlayson, 2011). Grounded theory starts with the data itself before moving on to reading the relevant literature and is therefore an inductive rather than deductive approach. However, it is not: an excuse to ignore the literature; the presentation of raw data; the testing of theory or an excuse to have no methodology (Gordon-Finlayson, 2011). The difficulty with using a grounded theory approach for this researcher to investigate the concept of boundary was the researchers previous knowledge, understanding of the concept in their own counselling practice and additional reading

of the literature which made a purely inductive analysis of the participants' accounts impossible.

The process of IPA

IPA does not adhere to a strict singular method, set of rules or guidelines when analysing data (Smith et al, 2009). There are however a set of strategies which are key to its implementation which are outlined by Smith et al (2009) which are: a close line by line analysis of experiential concerns and cares of the participants; the identification of emergent patterns (both convergent and divergent, and commonality and nuance) in single cases and then across cases; the development of a dialogue between the researcher, the data, their psychological knowledge and the meaning for the participants (i.e. a more interpretative account); the development of a structure or frame to illustrate the relationship between themes; for the material to be 'mapped' so as to trace the analytical process; an audit of the process and themes to support the coherence and plausibility of interpretations; the development of a full narrative (supported by quotes and/or a visual representation of the themes); and finally a reflection of the researchers own perceptions and processes. These strategies were implemented as part of the IPA analysis of interviews in this study and are detailed below.

The interviews were transcribed and then analysed. Analysis began with a read through of the transcript with brief notes of ideas and thoughts being added to the transcript. In addition, a separate journal was used to write out any particular quotes or areas which stood out on the initial read through. The use of a journal allowed much more detailed commentary and expression of thought than annotation on the transcript. The transcript was read through numerous times, following a similar process until common themes started to appear. Upon the appearance of a potential

theme or links between passages a thematic label was identified and recorded, and used to link with other relevant passages. It is important to comment here that once identifying themes it was important to not become totally focused on these initial links but still be open to other emerging themes and nuanced accounts within the data (this was initially difficult to do).

Brocki and Wearden (2006) argue that if the themes identified from IPA interviews are of significant comparison to the topic areas in an interview schedule then the researcher may be structuring the analysis before the collection of the data. Many of the initial themes that started to appear from the first stage analysis *did* appear to match the interview schedule and the initial literature review. This analysis *felt* descriptive and literal. The data itself was rich, however the analysis was both mechanical and too reductive – similar to say completing content analysis on the descriptive accounts of the participants. Interestingly, this analysis did emphasise that many of the boundary themes within the counselling literature were shared by participants. However, these themes were shared 'thinly' out across participants (i.e. examples for each theme existed but weren't necessarily consistently shared across interviews). This issue is explored further in the discussion of the findings.

<u>Focus of Experience</u>

As previously alluded to the analysis of the interviews was overwhelming and the emergent themes found were numerous and covered a very broad exploration of the concept of 'boundary'. Initially, although gathering very rich data from these participants, the emerging themes were completely overwhelming . For example, there was an identification of endless boundary types, applications of boundaries, psychological and social constructions within the text.

Point of reflection: Reflecting on this experience I believe that I was heavily influenced by the research literature that I had read and I was linking theoretical discussions of boundaries with evidence within the interview. I had lost, in part, what these participants were telling me about *their* experience of the concept of 'boundary'. It was at this stage that I understood quite clearly the importance of 'bracketing'. Previously, I had understood the meaning of this on a theoretical basis. However, now I understood it on a much more practical level. Essentially bracketing can be defined as "a process whereby the researcher refrains from positing altogether and takes an open approach to the data" (Finlay, 2011, p74). I have always questioned that this concept was indeed achievable (or useful) within the context of qualitative research given the difficulty of 'putting aside' one's own perceptions whilst analysing others. Furthermore, the application of IPA encourages the use of the researchers own interpretation in analysing the research data as long as these interpretations and perceptions are reflected and commented on as part of the research process (Smith et al, 2009). However, through the research process I came to understand bracketing not in this larger sense of the word (i.e. effectively blocking off my own perceptions and views) but by focusing on the individual experiences and perceptions of each individual participant account then the researcher can effectively 'bracket off' (to a certain degree) their own perceptions or indeed the accounts of the other participants. The word 'bracket' I would eventually come to see as unhelpful in this context and would argue that the phrase 'focus of experience' would be much more useful. That is rather than the researcher focusing on their own experience they focus on that of the participant (Finlay, 2011).

At this stage, it became apparent that another approach was needed to access the individual stories that were being told within the participant interviews. This involved the use of a 'pen portrait'. A pen portrait can be defined as a descriptive account of the participant, which summarises both some personal characteristics and the main themes from the data in a short statement. Hollway and Jefferson (2013) state that "a pen portrait serves as a substitute 'whole' for a reader who will not have access to raw data but who needs to have a grasp of the person who figures in a case study if anything said about him or her is going to be meaningful" (p65). The pen portrait was

appealing because it was a way of condensing the data and themes which had been found into a much more accessible form. This was purely a tool for focusing attention on what the participants were saying about the concept of 'boundary'.

It was, admittedly, unable to express many of the nuanced elements which the IPA analysis could, but it was able to direct the analysis towards and focus on what the main points or themes were for each participant. Furthermore, this clarity enabled consideration of the other themes and how relevant they were to the participants' experience when considered from this point of view. Finally, using a pen portrait also allowed a quick comparison between participants to examine the convergence and divergence of understanding and experiences. It was through the use of the pen portraits that there was an additional focus on the main aspects of each person's understanding of boundaries found in the interviews – a summary of these 'portraits' are in chapter five and are also discussed there.

Point of Reflection: To present a summary of the participants' accounts may seem counterintuitive when I have been arguing that the findings of this thesis are because of an in-depth analysis of the participant interviews. However, these pen portraits enabled me to highlight the general attitude of participants towards boundaries which then gave a point of comparison when completing deeper analysis.

The pen portraits took many of the themes identified in the IPA analysis and summarised them into short and easy statements about the participants' approach to boundaries. Through this process it became clear that rather than have a consistent view of boundaries each participant had a unique and idiosyncratic approach towards boundaries.

Through writing up these pen portraits it also became clear that this approach (or 'boundary attitude' as it came to be labelled) did not often fit in with the participants' understanding of boundaries (i.e. how they defined them) and it did not correlate with their modalities approach to boundaries. Therefore, not only did the pen portraits enable a focus of attention on the individual accounts rather than the broad themes it also enabled a greater comparison between accounts and raised further questions about the participants experience.

In addition, the pen portraits also highlighted how although there was a commonality of some themes across accounts it was the process of the boundary experience itself that participants shared rather than a shared understanding. Furthermore, although the process of responding to boundary issues could be followed across the accounts the actual experience was unique to each participant.

Interpretation and IPA themes

Data within IPA studies should be both "sufficiently interpreted and contextualised" (Brocki and Wearden, 2006, p99). Although the main focus of IPA is the lived experience of the participant the final reporting will always be "an account of how the analyst thinks the participant is thinking" (Smith et al, 2009, p80) because "the analytical process cannot ever achieve a genuinely first-person account – the account is always constructed by participant *and* researcher" - italics are authors own (Larkin, Watts and Clifton, 2006, p104). Despite this many IPA studies fail to mention the interpretative role of the researcher although it should always be there given the very nature of IPA (Brocki and Wearden, 2006).

After transcribing, reading and analysing the interviews it became apparent that although the analysis had been useful in exploring the participants' experience, and it

had elucidated interesting and nuanced aspects of their account, it had also failed to gain the deeper level analysis and interpretation that is both required and made possible through IPA (Smith et al, 2009). One criticism of IPA researchers is that they can sometimes be too descriptive in terms of their analysis of data (Parker, 2005). Certainly, this appeared to be true in respect of these interviews. A second stage of analysis on all of the interviews was necessary to rectify this.

Similarly, to the first stage of analysis the data would need to read, re-read and further notes made. However, this time the themes throughout each interview (including the more minor ones) were in the awareness of the researcher. Therefore, this allowed greater focus on the content of passages in relation to these broader themes. It also allowed quick identification of any divergences away from these themes. It is important to understand that this second stage of analysis was not an attempt to re-interpreting each interview in terms of the themes identified, but to gain a deeper analysis and understanding of the themes that had arisen. It was also an opportunity to test the validity of each of these themes, and examine if they still appeared relevant after a re-analysis of the text. Finally, using the pen portraits for the participants had helped to focus attention on the story being told by participants and thus enabled a deeper level of interpretation of the accounts. Following this second stage IPA analysis of all seven interviews four super ordinate themes emerged. These were *Protection of Self*; *Protection of Other*; *Boundaries as the Framework* and *Boundaries as Tools. A* diagrammatical representation and discussion of those themes are included in *chapter four*.

Deeper Analysis

The IPA analysis provided the themes outlined above. Although these themes provided a new insight into counsellors understanding and experience of boundaries

(with the dominant theme of Protection of Self) this further analysis and summary of themes still did not sufficiently do justice to the participants' accounts. Similarly, to the earlier analysis of the interviews delving deeper into the participant experience felt necessary. However, at this point I felt I had taken the IPA analysis to its conclusion with the super ordinate themes detailed earlier. Chamberlain (2011) highlights how texts on the IPA method lead researchers to produce exactly what they are expected to – 'subthemes' which link into broader themes. Chamberlain argues that this methodological approach can work to limiting researcher interpretation of the data as the researcher can assume that the process is finished when they have the super-ordinate themes. However, Smith (2011b) argues that 'procedural features' are far from over emphasised in IPA texts, rather they play a key part but interpretation is highlighted as just as important.

To consider the findings afresh and offer new interpretations there was further exploration of the literature on some of the themes identified in the IPA analysis. This included research on fear, shame, and professional identity both within the counselling literature but also in other disciplines. Through this extended research, the re-reading of the interviews and a review of the superordinate themes the researcher became aware of being immersed within the 'hermeneutic circle'. There was a realisation that the (near) linear path that had been followed for the IPA analysis, although useful, was not sufficient for these participants. The procedural aspects of IPA did indeed appear to 'limit' the interpretation of the data as suggested by Chamberlain (2011).

This resonates with Smith et al's (2009) statement that "it is a key tenet of IPA that the process of analysis is iterative – we may move back and forth through a range of different ways of thinking about the data" (p28). The researchers own relationship with the data shifted according to the hermeneutic circle as there was a realisation that

"entry into the meaning of [the] text can be made at a number of different levels" (p28). It was through this awareness that it was decided to record and include IPA which approached the analysis of the interviews through creating themes, but then also to consider alternative ways of presenting the participants boundary experiences.

Point of reflection: Two points influenced this decision. First, I was struggling with terminology when looking at the participants' accounts. I was often confusing their understanding, experience and approach towards boundaries as each aspect of their accounts overlapped with the other. This led me to writing out a definition of each aspect to make it clear to myself what was being discussed. By completing this process, I identified five specific terms that represented different aspects of the participants' accounts. It was clear to me that these terms would fit into a specific decision-making process for counsellors and this was drawn up. This was then checked across all the participants' accounts to ensure its trustworthiness. These terms and process map are presented and discussed in *chapter five*.

The second element that became clear was that the participants although finding it difficult to articulate their understanding of boundaries were quite easily able to discuss their response to boundary issues. This led me to consider deeper analysis of these responses and the proposed Boundary Response Model (BRM) which is represented in *chapter six*.

To fully represent participants understanding and experience of boundaries it was important to represent how participants were responding to boundary issues. One of the main themes that was identified to be of importance was - Protection of Self. This theme highlighted the participants' use of the boundary concept as an important aspect of protecting themselves particularly when responding to boundary issues. It is

this theme which creates the backbone of this thesis and which has interesting implications when considering the influence of the boundary concept in practice.

Creating Models – combining data, theory and interpretation.

Smith, Jarman and Osborn (1999) identifies that IPA is *not* a "prescriptive methodology" (p238). IPA is "not concerned with making generalisations" (Clarke, 2009, p38). However, whilst the overarching aim of analysis using IPA is not for generalisability across the participant population neither should it be purely the recounting of their accounts (Brocki and Wearner, 2006). Researchers are therefore encouraged to be innovative in their approach to analysis and interpretation (Smith et al, 2009).

The methods used in this thesis to create both the models were used because the themes generated by IPA were not enough to represent the idiosyncratic understanding and experience of the boundary concept of participants. Therefore, the models were created through an IPA analysis of the accounts, the pen portraits, the extended reading in other areas (such as literature on shame and fear) and the researchers own understanding and experience of boundaries.

Validity, Reliability and Reflexivity

Validity in Qualitative Research

The search for validity in qualitative research is highly debated and disputed (for example see Angen, 2000; Brocki and Wearden, 2006; Cho, 2006; Davies & Dodd, 2002; Healy and Perry, 2000; Morse, Barrett, Mayan, Olson and Spiers, 2002; Rolfe, 2006).

BACP guidelines into ethical research state that researcher competence in the design, planning and carry out of research will ensure that it has a meaningful and has a valid contribution to knowledge (Bond, 2004). Furthermore, counselling research should

seek high levels of trustworthiness and integrity through openness and accountability (Bond, 2004). However, Elliott and Williams (2001) argue that high quality qualitative research is unable to have secure advanced planning because it is ever evolving and changing. As I have already evidenced earlier in this chapter the method deployed in this study (i.e. IPA) was not sufficient enough to analyse and represent the participants' accounts (although it did form the basis of the later analysis). Therefore, this study benefited from both the more structured and planned IPA approach whilst also needing to veer away from it to deepen the interpretation and analysis of the data.

Angen (2000) argues that as researchers we want assurances that we have 'done the right thing' to be able to claim that because we have completed 'all the right moves' we have therefore established 'the truth'. Morse, et al (2002) proposes that we need more common terms to be used from mainstream science to ensure reliability and validity in qualitative research. However, Angen (2000) argues that life is too fluid and complex to find 'the truth'. Similarly, Cho and Trent (2006) argue that a researcher "must explicitly consider the degree to which the research purpose, question, and actual acts intertwine with an embedded, process view of validity" (p327).

Smith et al (2009) attempt to consider some of the qualitative theories on how to achieve validity in IPA. However, Rolfe (2006) argues that the term 'qualitative' should be restricted to the descriptions of data collection methods and not referred to as a paradigm within itself because there is no paradigm which incorporates *all* qualitative methodologies. Therefore, the validity of each methodology should all be judged on an individual basis rather than collectively.

<u>Validity in IPA</u>

As a method of qualitative research "IPA is inevitably subjective as no two analysts working with the same data are likely to come up with an exact replication of the others' analysis" (Brocki and Wearden, 2006, p98). However, this does not mean that the validity and trustworthiness of the findings, plus the quality of the study cannot be assessed (Frost and Kinmond, 2012). Brocki and Wearden (2006) found that many published IPA studies varied in their approach to assessing validity. For example, some studies checked their analysis and interpretations with other professionals (either associated with the research or independently); some studies had a separate analysis of accounts by different researchers before coming together to create a common framework of analysis and others sought participant feedback on themes and interpretations. Giorgi (2011) argues that IPA's "methodical procedures do not meet the criteria of good scientific practices" (p215) but IPA does not aim to be 'scientific' certainly not in the traditional sense of the word.

However, Smith (2011a) proposes a set of criteria for establishing the quality of IPA studies. In this criteria Smith proposes that for an IPA study to be 'acceptable' for publication it needs to: submit to the principles of IPA (i.e. be phenomenological, hermeneutic, and idiographic); offer transparency for the reader (so they can see what has been done); have a coherent, plausible and interesting analysis; and offer a sufficient density of sampling to evidence the reported themes. To raise the status of the study to 'good' it should also be: well focused with in depth analysis; strong data *and* interpretation; and the study is enlightening and engages the reader (Smith, 2011a). This study has adhered to these principles. The principles of IPA have been upheld throughout and detailed on multiple occasions throughout this thesis. The data from this study is rich, indeed it could have been analysed and interpreted in numerous

different approaches (this is explored further in later sections). The depth of analysis has gone beyond the superficial and delved into the deeper meanings of the participants. Indeed, it is argued that through this deeper level of analysis (and interpretation) this thesis contribution to knowledge is found.

Interestingly, Smith's (2011a) criteria does not require the validation or trustworthiness of the findings or interpretations to be assessed by either the participants of the study or another professional apart from the researcher. Although the publication of an IPA study ensures that it has at least been peer reviewed and Smith's (2011a) criteria also aims to ensure that the relevant themes are sufficiently evidenced, which is arguably enough to assure the validity of the research. The validity of the findings from the IPA analysis in this study is supported by representative extracts within *chapters four, five and six*.

In identifying the 'trustworthiness' of any analysis Rodham, Fox, and Doran (2015) suggest a collaborative approach between researchers is needed such as a sharing of notes and all researchers listening to recordings etc. Within this study I was the sole researcher and therefore was exclusively accessing the interview recordings and transcripts for analysis. Indeed, a sharing with others of these recordings would have been unethical and possibly breached the anonymity of the participants. However, the transcripts and ongoing analysis was subject to review and consideration by the supervisors of this study which sought to ascertain a level of trustworthiness of my analysis. Indeed, these reviews created fruitful discussions and further aspects of analysis for this study (and are discussed in later sections).

Rolfe (2006) argues that ultimately the quality of a qualitative study cannot be assessed through previously identified strategies and procedures because quality is

only revealed through the writing up of the research report. Rolfe (2006) also suggests that the responsibility of assessing the validity of a piece of research lies with the reader, who should also be a practitioner of the methodology being assessed. In this regard, Rolfe argues, that to assess the validity of a piece of research the assessor needs to have some working knowledge and experience of it rather than a purely academic understanding. Through a clear presentation of my research 'journey' and a transparent approach to the research process enables readers (particularly IPA researchers) to assess the validity of this study and the proposals resulting from it.

Rigour

Any report of IPA research needs to be rigorous (Smith, 2011a; 2011b). Smith (2011a) asserts that it should report on the prevalence of each theme with a good representation of the data. Furthermore, when using extracts, they should offer insight into how each theme converges/diverges and how it is representative or variable so as to evidence its depth and extensiveness (Smith, 2011a). This study explores the participants' accounts in detail offering multiple extracts to ensure findings are rigorous. However, Smith (2011a) proposes that good IPA research should offer evidence of its 'themes' with a certain amount of its participants. I would challenge the notion that there needs to be a minimum number of participants to evidence a theme or finding as proposed by Smith (2011a) because interesting findings and insights can be found in one participant account rather than just in the many.

Reflexivity

In IPA studies researchers should offer a clear acknowledgement of their own areas of interest in research; theoretical underpinnings; and reasons for completing the research thus enabling readers to understand the role of interpretation by the researcher (Brocki and Wearden, 2006). However, as Finlay (2002) states the

"process of engaging in reflexivity is full of muddy ambiguity and multiple trails as researchers negotiate the swamp of interminable deconstructions, self analysis and self disclosure" (p209).

I have outlined both my personal and professional motivations for undertaking this study in earlier chapters and the research interests of this study. I have also detailed an extensive audit trail of decisions for each stage of this research process (Rolfe, 2006).

I acknowledge the risk of boundary issues inherent within my role as practitioner-researcher (Etherington, 1996; Dickson-Swift et al, 2006) and discuss the impact of these two roles within the research process.

Frost, Nolas, Brooks-Gordon, Esin, Holt, Mehdizadeh and Shinebourne (2010) speculate that there may be a link between the personality of the researcher and their choice of method. The role of interpretation in IPA analysis does appeal to my inquisitive and questioning nature. Furthermore, theoretical groundings of this study are based in phenomenology which 'speaks to me' as a researcher and counsellor as it explores the 'lifeworld' of participants and allows me as a researcher to go deeper into their world and experiences.

It was important that I applied "a more curious and reflexive approach" (Rodham, Fox and Doran, 2015, p69) to my own reaction to the interviews and transcripts. I have therefore reflected on my own position as researcher throughout this thesis. I have also detailed different aspects of reflexivity throughout this thesis when they have been particularly significant or poignant.

I did not use a reflective diary whilst completing this study. Supervisors recommended that it would be useful to complete one as I embarked upon this study. Initially I attempted this but found the process extremely contrived as I wrote down thoughts and feelings related to the research process. Indeed, I found this process confused rather than added any clarity to the research process. I did however make some notes at relevant junctures in the research process (moments of importance or reflection which felt important or took the research in a different direction). These are highlighted throughout the thesis, particularly the findings section. However, now that the thesis is completed I look back and believe it would have been useful to complete a more reflective diary. My initial feelings of contrition were due to a lack of understanding about what to include in such a diary. Indeed, through the development of my research skills, indeed extended reading around IPA and other qualitative methodologies has enabled me to consider some of the deeper questions which I would use a reflective diary for. It could be argued that without such information it is difficult to assess the quality and validity of this work (Rolfe, 2006). Arguably, a reflexive diary (when used properly) may have offered further insight into the interpretation, analysis and reflexive approach presented here. However, this study has still resulted in detailed reflexivity and a valid contribution to knowledge without using one.

Methodological Issues

One challenge was repeatedly engaging with the same interview repeatedly on numerous occasions, and still being open to new emergent themes and exploring multiple links within the interview. It was important, therefore, to complete the analysis of this interview (and future interviews) over multiple days, weeks (and sometimes months), so that the information that was being read could be processed effectively. This included having breaks from the analytical process. Another useful strategy for

engaging with the data was to listen to the interview again, whilst looking at the transcript or separately from it. This process was useful as a reminder that it was a person's experience that was being analysed and not purely an abstract task associated with the analytical reading of a text.

Summary of methodology

This thesis interviewed seven qualified and practicing counsellors about their understanding and experience of the concept of 'boundary'. These interviews were transcribed and analysed using multiple qualitative methods such as pen portraits and Interpretative Phenomenological Analysis. The analysis of these accounts took a 'non-linear' route to draw its conclusions including the exploration of alternative areas of literature to deliver new and interesting insights. The validity and trustworthiness of this study is evidenced through a detailed discussion of the research process in this chapter and the use of participant extracts throughout the findings chapters.

Presentation of findings

The findings of this research are presented in the following three chapters.

The next chapter – chapter four – details the findings from the IPA analysis. The themes from this analysis are considered in context and their link to the two proposed models is highlighted.

Chapter five details the first model proposed by this thesis. This model maps out the process of decision making for counsellors when dealing with boundary issues. This model is represented in diagrammatical form with four new terms proposed to represent different aspects of this process.

Chapter six represents the second model proposed by this thesis. This is the Boundary Response Model (BRM) which looks in more detail at the different responses of participants when faced with boundary issues.

Chapter Four: Findings

IPA analysis and findings

This section examines the *Findings* from the IPA of participants' interviews. There are two main themes which resulted from the analysis. These were *Protection and Safety* and the *Structure of Therapy*. These could be broken down into four smaller themes. Protection and Safety can be split into *Protection of Self* and *Protection of Other.* Structure of Therapy can be split into *Boundaries as the Framework* and *Boundaries as Tools*. These themes are explored in the following section. This starts with a diagrammatical representation of the themes, and a summary and discussion of each theme individually. Evidence of these themes is in line with Smith's (2011) requirement for rigorous IPA research as discussed earlier. However, some of the themes identified are not evident in all participants (indeed some are only evident in one participants account) but has been deemed relevant to the theme and discussion so has been included. Participants have been labelled by letters of the alphabet. So, participant A has been labelled PA, participant B has been labelled PB etc through to participant G being labelled PG.

Despite the difficulties found in the IPA analysis (this was discussed in the previous chapter) there were superordinate and subordinate themes found and these did influence additional analysis and the creation of the models proposed in this thesis. Therefore, it is useful to consider them here in full.
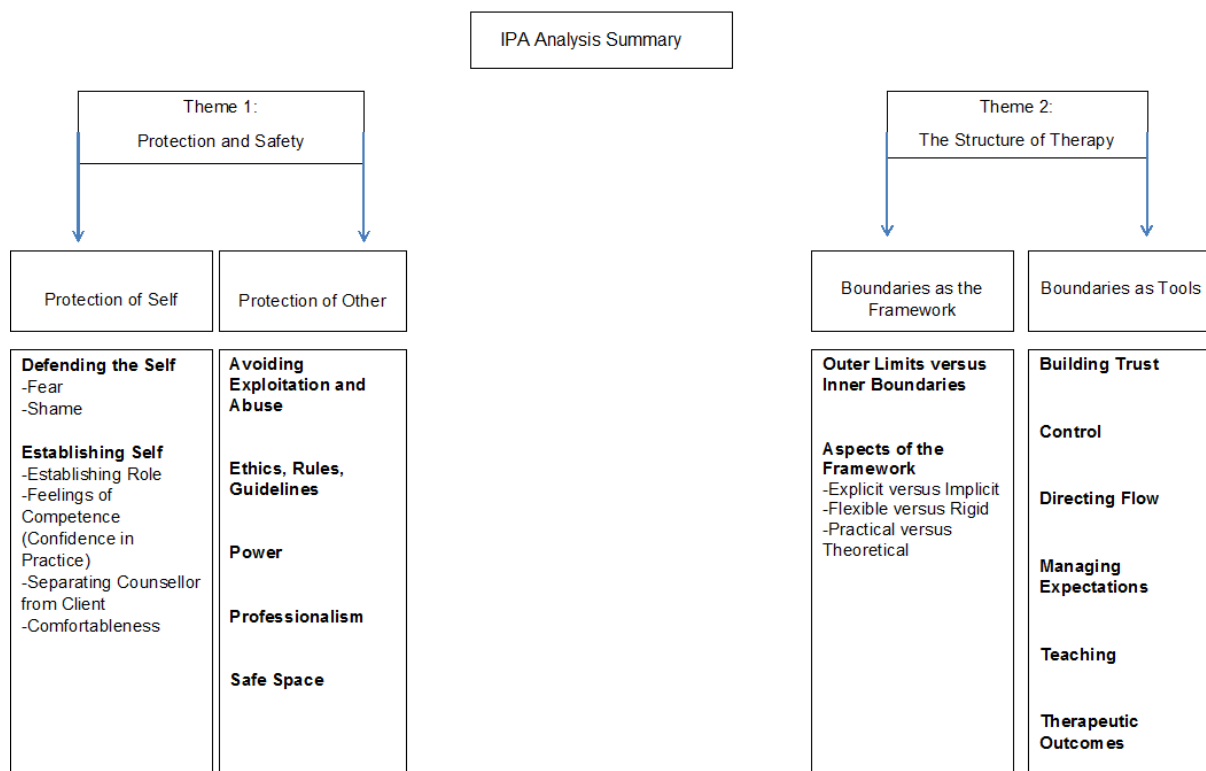
Figure 1: Diagrammatical Representation of the IPA analysis

Theme 1: Protection and Safety

The first emergent theme was that of *Protection and Safety*. This theme dominated the narratives and was both overtly and covertly identified by participants as one of the main purposes of boundaries in their practice. This theme was split into two further subthemes which are *Protection of Self* and *Protection of Other*.

Subtheme: Protection of Self

The first emergent subtheme was that of *Protection of Self. "I suppose I think automatically about the relationship boundary really, just, erm, on several themes. One – protection, protection of yourself"* (PA, L17-18). All participants identified how boundaries were used to protect themselves.

The literature acknowledges that boundaries protect the counsellor as well as the client (BACP, 2015; Kent, 2013) and that counsellor safety can be just as important to consider as that of the client (Despenser, 2005; 2007). However, it was surprising at how dominant this theme was when we consider that the majority of the literature on boundaries relates to the protection and safety of clients (BACP, 2016a; Bond, 2015; Kent, 2013; Proctor, 2014; Sarkar, 2004). Even when participants mentioned boundaries protecting both themselves and others they often listed themselves first which suggests they prioritised themselves first. *"…protection of yourself and protection of your client"* (PA, L17-8). *"…my personal safety and the client's personal safety"* (PB, L9-10).

(**Point of Reflection:** One reason that the *Protection of Self* theme may be more dominant than the *Protection of Others* may be because the questions in the interview schedule related to the counsellors themselves rather than their clients. For example, questions/prompts were designed to explore participants lived experience and arguably would result in a greater focus on themselves rather than their clients. However, the very nature of counselling is an empathic understanding of others, and it is still surprising that the majority of participants focused on the protection of themselves rather than protecting their client. This theme is picked up throughout this thesis and further reflections on this point are discussed later as they influenced the direction of the Boundary Response Model proposed later).

The BACP (2015) refers to the importance of 'care of self as practitioner', which includes counsellors protecting themselves from physical harm; monitoring their physical and psychological wellbeing; seeking professional support and services when needed; and keeping a healthy work/life balance. Therapists can acknowledge the need for self-protection with clients in a variety of contexts (e.g. Moore and Jenkins,

2012). Participants understood that boundaries were an integral part of protecting themselves and keeping themselves safe within their practice. "…*it is keeping yourself safe*" (PB, L526). "…*it is a measured approach to conversation designed to keep everybody safe*" (PD, L48-9). "*I think that they are very important. I think they are important for me because it's about keeping me safe*" (PG, L101-102). *"…without them it would be a mess, it would be very messy (slight laughing), I would be a nervous wreck and completely depressed"* (PA, L831-833).

All participants identified the need to use boundaries to keep themselves safe. This could be split into two further different sub themes –*Defending the Self* and *Establishing Self.*

Defending the Self

"…on a personal level it is sometimes about self-preservation in certain situations…" (PA, L269-270)

One of the main ways in which participants used boundaries was as a defence technique to protect themselves. This theme was labelled - *Defending the Self*.

Participants used boundaries to defend themselves from a variety of potential threats. *"I think they are important for me because it's about keeping me safe"* (PG, L101-2). Each of the main therapeutic traditions highlights how boundaries can be considered a form of protection for self (Davies, 2007). These often relate to intrapersonal boundaries that is boundaries based within the mind. For example, in psychoanalytic theory the id, ego and superego, in addition to the different levels of consciousness experienced, attempt to protect the self from uncomfortable awareness of unwanted feelings and thoughts (Davies, 2007). One of the earliest references to boundaries is

from Freud, when he mentions 'reizshutz' a protective shield, or barrier (around the ego) protecting against stimulation (from the id and the outside world) (Hartmann, 2001). This is also true in person-centred theory, where intrapersonal boundaries exist to protect the organismic self from [the threat of] a painful external reality (Rogers, 1957). However, these theories aim to serve the therapist by giving them a greater understanding of their clients. **There is little discussion in the literature on how boundaries can be used defensively by counsellors to protect themselves in therapy.**

PA's quote at the start of this section highlights how in certain circumstances 'self-preservation' is what the counsellor needs to focus on rather than the needs of the client. When the counsellor is under threat then boundaries can be used to defend themselves. PA suggests that this is a fall-back position i.e. when the self is threatened then she will work towards self-preservation before anything else.

Hartmann's (2011) Amoeba Principle can be used to understand this position. The Amoeba Principle proposes that our boundaries can change significantly when we are challenged, damaged or feel threatened. This threat or perceived threat can lead to a thickening of boundaries. Similarly, to an amoeba which spreads out its body in peaceful conditions and retracts and hardens when attacked or threatened.

PA is expressing this ultimate position that when under threat she resorts to self-preservation and will thicken up her boundaries to defend the self. There are multiple examples from participants within the interviews which evidences boundaries being used as a way to defend the self.

In the following section I will examine some of the areas that participants felt the need to defend against. To understand these threats from the lived experience of the

participants these threats have been grouped under the two motiving affects which were identified as part of the participants experience. These were feelings of *Fear* and *Shame.* Both of these themes heavily overlap and therefore elements of each theme are discussed and highlighted throughout.

Defending the Self: Fear

"It's your job, you go in to this, and you know your biggest fear comes straight through the door" (PB, L625-626)

Fear was often an aspect of participants' experience of the boundary concept (PA, PB, PC, PD, PE and PG). Some participants (particularly PA) reported fear as an important aspect of their experiences of boundaries and boundary issues. However, other participants (PE, PF) did not particularly associate fear with their experience of boundaries.

Participants were often fearful of boundary relates issues. "…*your biggest fear comes straight through the door*" (PB, L626). Boundary issues that created the biggest fears in participants were related to physical attraction and discussing the erotic, the threat of violence, breaking confidentiality and charging fees. This supports the notion that boundary issues can provoke fear and anxiety within therapists (Pope and Vasquez, 2016; Reeves, 2011).

Participants used boundaries to defend themselves from fear. This was often characterised by participants actively seeking to avoid or remove themselves away from their fears – "*but actually you are in fight or flight*" (PA, L421-2) in a bid to keep

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themselves safe. Similarly, Kierski (2014) found that therapists could 'back away' from clients when they felt threatened by feelings of anxiety.

Participants' responses to their fears are again evidence of the Amoeba Principle in action. The Amoeba Principle suggests that individuals will respond to a threat by thickening their defences or boundaries (Hartmann, 2011). Participants often expressed a defensive reaction to their fears in therapy, which resulted in a thickening of their boundaries (i.e. a defensive reaction), and a distancing from their clients. *"I was thinking my god how are you coping, so really my barrier went down... but quickly as she said – well don't, that my barrier just shot right up, and I thought whoa what am I saying, you know?"* (PA, L913-916).

The threats shared by participants broadly echoed those identified by counsellors in Smith's study (2003a) which explored counsellor fear. Smith identified three thematic areas which were: fear of losing control/being overwhelmed; fear of being separated from a group through disapproval or rejection; and fears of physical and/or sexual assault.

Similar to Smith's (2003a) participants counsellors in this study shared both experiences of fear from actual events and those which counsellors believed may happen. *"I kind of wonder you know, a lot of these things that I hold, I think are very firm things, and I think well what happens if I am in practice, at home, and they would have my number and they would have access to me, and they could suddenly pull up outside my house at twelve o'clock at night in a desperate state, you know?"* (PG, L618-623). These experiences of fear often resulted in suspicion or wariness on behalf of the counsellor. *"There is any number of things that could potentially happen"* (PG, L623).

Totton (1999) argues that counsellors' fears of their clients is an accompaniment to feelings of potential resentment and hatred towards our clients which is expressed by counsellors in their demonization of abusive therapists. However, participants of this study did not share views which suggested that they resented or hated their clients. Certainly, they expressed their own fears and anxieties regarding their own and their clients' behaviour. However, this did not appear to be related to deeper feelings of resentment towards their clients.

This section will examine some of the fears of participants and how they impacted on their experience of boundaries within their practice, it will also highlight how participants used boundaries to defend themselves from fear.

-Fear of Complaint

Some participants in this study were fearful of complaint and litigation from their clients (PB, PD). Smith's (2003a) study into the fear of counsellors found they often feared being separated from a group through disapproval or rejection with a focus on a fear of judgement from supervisors or seniors. These fears were directly related to the prospect of litigation and investigation of the participants practice. Kearns (2006) suggests that there is an increased sensitivity towards the shame phenomena for therapists because the supervisory relationship is held in a more litigious and market based context resulting in increased 'performance anxiety' for therapists. Kearns (2011) believes that the process of being complained against can result in such intense feelings of shame for the counsellor that it stifles their practice. If this is true, then it is also likely that the fear of complaint could also impact upon the counsellor's ability to practice successfully. In this study participants used boundaries to protect themselves from complaint and the threat of legal action.

Participant B is fearful of complaints from clients and used boundaries to protect herself.

"*…you know rules that are set sometimes that unfortunately we have to keep to, because somebody along the way will want to, erm, sue you for something that you've done…*"

<div align="right">(PB, L855-57)</div>

In this example, PB appears regretful at the need to keep to the 'rules' but felt that it was a necessary aspect of therapy to keep herself safe. Similarly to PD she appears to see boundaries as a form of 'constraint' (PD, L6). PB saw boundaries as important ethical guidelines with which to protect herself from any potential complaints.

"*And the client has gone on to do the same thing to somebody else, so because she kept her boundaries with her its worked out better for her, but again those are one of the big reasons why you have the boundaries…Because no matter what someone is going to accuse you of, in that room between you, nobody can say, and they will always go with the client*"

<div align="right">(PB, L565-569)</div>

PB believes that by staying within the clear boundaries of her role (as she reports her colleague did) then she will be safer from any complaint being upheld against her. Her account conflicts with itself as she says that the client will always be believed above the counsellor, yet her colleague seemingly was able to challenge the complaint against her because of the clear boundaries that she put in place. PB believes in the security of clear boundaries with her clients to keep her safe from complaint although this belief is still underpinned by a fear of any complaint against her. PB's fears of not

being believed appear to mirror those of clients who are fearful of complaining (MIND, 2010).

PB appears to distance herself from the client's complaint when repeating this story by questioning their emotional state and motivations (Bates, 2006; Gabbard and Hobday, 2012), she states *"'…he has ruined my brain' you know? 'the counsellor has ruined my brain…'"* (PB, L860-861) and *"…and the client has gone on to do the same thing to somebody else"* (PB, L869). This acts as a form of protection for PB, whether the complaint is truthful or not, PB is able to avoid any deeper examination of this by laying blame with the client.

Participants were also fearful of breaking boundaries because of the risk of complaint. This is understandable when client complaints are more likely to be boundary related (Khele, Symons and Wheeler, 2008; Symons, Khele, Rodgers, Turner and Wheeler, 2011). In contrast, Reeves (2001) found in his study of counsellors who work with suicidal clients that some counsellors avoided the fear and anxiety of litigation and malpractice by breaking confidentiality at an early stage of therapy when concerns were raised.

The use of physical touch in therapy can raise therapists' fears surrounding sexual arousal or physical aggression in clients as well as the possibility of future litigation (Westland, 2011). PB removed the use of touch from her practice because of organisational rules. However, PB justified this rule because of any potential misunderstanding of her use of touch and her fears surrounding possible litigation. *"So if there is any possibility they could claim against you, then touch is limited"* (PB, L150-1). Aquino and Lee (2000) acknowledge that removing the use of touch from therapeutic practice often aims, in essence, to protect the client but that decisions

need to be based on clear clinical principles rather than because of fearful responses to mass media and potential litigation.

Bates (2006) argues that counsellors avoid considering the possible advantages that complaints may bring through greater introspection and analysis of practice. Kearns (2011) suggests that as well as a fear of the complaints procedure itself counsellors' reaction to complaint is also based on a more "primitive reaction" (p6) from the counsellor. This, argues Kearns, is about feeling 'caught out' even when the counsellor has done nothing wrong and a presumption that the outside world will never understand what actually happened in the therapy room. This view is evidenced by PB when she says "*…and they will always go with the client*" (PB, L875).

-Fear of Violence

Participant A had a fear of physical violence within her counselling sessions. PA identified boundaries as an important way of maintaining her physical safety within the counselling sessions and defending herself. PA had a particular focus on the potential for violence within her counselling sessions.

"Yeah, and I think that can be a physical thing as well, I mean I`m not hugely well built, or strong, to restrain or defend myself for a start, and I mean, fortunately I have never, I`ve never had to, I mean I have had a few threatening behaviours sort of thing, that I have felt intimidated, but, erm, so it is important to think about that protection issue really"

(PA, 229-301)

For PA her physical size compared to her clients and her limited ability to defend herself contributed to her fears of violence. Interestingly, her fears were not only raised by the thought of physical threats, but also any intense emotional outburst from clients.

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"I never feel that I haven't got the power to control it, I think I have been very lucky maybe as well, and also the nature of the work maybe, has made it, twice I have felt completely intimidated with a finger in my face…and, potentially they could of hit me, you know, erm, and I've removed myself physically first, and kept very calm and used a lot of my skills to just tone the conversation down, and resolved it, each time we've not actually ended the session we've resolved it"

(PA, L631-9).

This suggests a deep rooted fear of violence from PA and one which impacted on her use of boundaries in therapy. Despite stating that she never feels powerless to control the situation the fear of violence is still evident. This fear appears to be as a result of being isolated and feeling helpless from *"…being on a one to one with someone, who I don't know…"* (PA, L419). Furthermore, PA sets up her counselling room to prepare for this type of threat. *"I have just realised when I am sat here, but when I counsel I always sit in this chair, next to the door here"* (PA, L380-2). Although many counsellors may take these type of precautions PA appeared particularly concerned about the propensity of violence from her clients. *"…she didn't know where to put herself, physically, just absolutely lost it and erm, and I did fear for myself at that point I thought she was going to hit me"* (PA, L641-644).

PB also implied the threat of physical violence just once in her interview when she identified the need to restrict clients from bringing anything dangerous into the therapy room. *""would it be alright for me to bring my scissors in here?" and she said I know we are not allowed to bring things in, but I hope it's alright, you know she knew what it was about because some of the clients could be quite bad"* (PB, L651-652). PB does not appear to have a fear of violence from her clients, in contrast to PA. PB

acknowledges that other clients could be 'quite bad'. I have interpreted this to mean other clients could be potentially violent when said this in relation to the client bringing in scissors to the session.

Despenser (2005; 2007) highlights therapist fear and their awareness of any threat as important factors to consider when assessing their own safety from physical violence or assault from clients. Similarly, Smith (2003a) identifies fear as important for heightening a counsellors senses and being alert in session, but warns against it becoming a barrier to effective therapy. Interestingly, PA was unaware of her fear of violence and it was only brought into her awareness through the research process. *"But what I didn't realise is, and even now talking to you, would be how much a part of that would be on my mind"* (PA, L416-417).

-Fear of Judgement

Some participants expressed a fear of judgement from others (PA, PB, PC, PD, PF, PG). This included clients as well as other professionals and colleagues.

Research suggests that therapists can experience fear of judgement from their clients before expressing personal aspects of themselves (e.g. Moore and Jenkins, 2012). However, Smith (2003a) suggests that counsellor fears are in some way representative of an underlying existential fear shared by all. Smith says "[w]hile the fear of being accused and found wanting may reflect fear of managers, supervisors and seniors within organisations, it also suggests an underlying ontological fear which may pervade the very nature of existence" (Smith, 2003a, 234). The fears shared by the participants in this study could represent an underlying fear of being 'exposed', and that they are to be judged as incompetent in their practice, which infers an anxiety about being shamed before their peers.

PD expressed a fear of being judged by the tutor who originally taught him and used this to guide his practice. *"I carried that with me all these years. Do you know what? That is not bad. That is a not bad rule of thumb. So if you do something in counselling that you wouldn't want to tell your original tutor, it is likely to be wrong"* (PD, L117-120). Here, PD expresses his 'internal supervisor' which guides his ethical decision making and approach to boundaries. For PD if he would be embarrassed to tell his original tutor then he believes his actions are ethically wrong. This position removes responsibility away from the counsellor and places it with the original teachings of the previous tutor. This position is also wrapped up in PD's acceptance by his peers as he resolves his ethical choices by referring to a moral sign post – his original tutor. This reduces PD's fear of being judged (particularly by his tutor) because he is following their guidance rather than his own.

Similarly, PG started her counselling career by questioning what her tutor would do. *"I kind of felt that I had to, that I`ve got to be true to person-centred, must stay working in this way, I could hear my facilitator's voice and I used to think what would he say, if he could see me now"* (PG, L318-21). However, PG was more fearful about breaking the boundaries of the person-centred tradition than being judged by her original tutor or others.

Wasdell (2011) argues that the advancement towards the accreditation of psychotherapy in the U.K. furthered two forms of behaviour. Firstly, higher standards, better quality services and the upholding of ethical values. However, it also furthered a more nuanced dynamic and motivation linked to unconscious processes of 'transference, projection and collusion'. If accreditation is, even in part, motivated by a fear of clients and a way of justifying the delivery of counselling rather than to benefit clients how useful can it be? Similarly, PD's ethical decision making appears to be

used to justify his own choices (and escape his fear of judgement from others whether that be colleague's or his original tutor) rather than necessarily for the benefit of the client.

Participants did not appear to identify accreditation or link it in any way with boundaries in their practice. However, it is always possible that the general move towards accreditation and professionalisation had influenced them anyway. PC's focus on the needs to be 'professional' and maintain a professional stance was an important aspect of her practice and she appeared fearful of others judgement if this was something she could not maintain. "*All the professionals just won't do it*" (PC, L219-20). Similarly, PG's bending of the rules for her clients appeared to result in fear, as she decided not to share this experience with her colleagues or supervisor. *"I don't know what college would say about that and I never asked anybody and had to say I am telling you this now that I never sought permission to do it"* (PG, L155-7).

-Fear of Losing Control

"…control is very much about boundaries…" (PC, L281)

Participants often expressed a *Fear of Losing Control* in their practice (PA, PB, PC, PE, PF and PG). The majority of participants also identified boundaries as an important aspect of staying in control (PA, PB, PC, PE, PF and PG).

PA's interview evidenced the most prominent fears about losing control in her counselling sessions. This is evidenced in her focus on the rules and boundaries of her sessions. *"…my next rule is that I stay in control"* (PA, L841-842). *"Still having those rules and boundaries in place, to...to make sure that the session is run to a ...best that you can run it..."* (PA, L742-3).

PA also discusses the possibility of the client losing control.

"And the staff there know I have got someone in, so that is a boundary issue really, and it does protect the client because if they lose... lose control of their emotions they can get more help than I can physically offer as well"

(PA, L384-6).

PA argues that there are additional staff available for the client if they lose control of their emotions for the client's protection. However, I would argue that it is PA who is actually in fear of losing control of her sessions and that it is reassuring for her that the staff are outside the sessions. Realistically additional staff would not be able to do more for a client than PA would in her sessions and it would not necessarily be appropriate for them to do so. However, this depends on what PA means by 'lose control of their emotions' although read in the context of the rest of her interview reasserts PA's fear of extreme emotion and the risk of potential violence leading from that. PA uses boundaries to stay in control of her sessions by ensuring that she has set out the expectations for the client. *""I'm feeling uncomfortable this is not how we set it, I`m sorry I am not going to continue if you carry on really", it's a way out, of er a situation sometimes and I`ve been under threat several times"* (PA, L356-8).

Similarly, PB describes a lack of control towards the life of the client outside of the counselling session and her fear of what may happen and what she could actually do. *"I had one client at the mental health team who called me every time she tried to kill herself, and it was on a continuous basis and it went on for about six months"* (PB, L426-8). For PB she was able to use boundaries to take control back of the sessions, and relay to the client that she could not do anything to support her outside of these sessions. *"…it was initially quite a big issue, where I would say "I can't work with you*

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if you keep doing this it is not in our contract" – I can't help her, you know" (PB, L447-9). Although PB appeared to still have residual fear of not being in control of this and not being able to help she realised that this was part of protecting herself. PB acknowledged the impact of being too available to clients outside of sessions and the resulting fear that ensues. *"…at first I`d be sitting there reading them [texts] thinking ooooh, you know"* (PB, 522-3). However, she recognises the need to reinforce boundaries to protect her emotional self. *"That's wrong, and that I`m taking on something that I shouldn't be taking, so again it is keeping yourself safe"* (PB, 525-6).

The biggest fear expressed by participants was the fear of losing control of their emotional self (PA, PB, PC, PE, PF, and PG). *"…you are feeling it with them really, empathising and you know, erm, emotionally looking after yourself, I am very mindful of, because I can see potential for it upsetting my emotional self"* (PA, L445-448).

Miller (2000) relates many of the therapist fears surrounding the loss of control in therapy as related to the body. For example, the client becoming too emotional, too angry or too noisy; not stopping the sessions on time or the shame of the client not returning can all result in clients responding with their bodies. For example, becoming physically angry or expressive, staying put when a session is over or not returning for future sessions. Miller is highlighting how counsellors do not have control over the physical presence of their clients and the resulting fear that ensues. This is evident in PA's disclosure of her fear of violence (detailed earlier) which ultimately could be argued to be a fear of losing control of the session rather than necessarily a fear of an actual physical assault.

PE is frightened when she experiences bodily changes when working with drug and alcohol clients. *"…when I first experienced it I was quite anxious, so I was thinking*

what on earth's the matter with me I felt fine before what's going on" (PE, L466-8). PE fear here surrounds losing control of herself and her body as the connection between her and the client is disrupted. PE reports that the client's drug and alcohol use has disrupted their connection and she has felt it in the therapy session. PE is uncertain why she feels the way she does and who the feeling is coming from (her or the client). PE uses boundaries to regain control and ground herself in her own feelings.

PA appears to express a fear of crying in front of clients. Despite asserting that she can control it. PA appears to have created a system to justify her tears if she cries. *"I am not worried if I do cry, so it's one those, the boundary is there, if I do...if I did have a cry, I can't ever remember crying but I ...I`m ...I`m quite strong about controlling my tears"* (PA, L838-840). For PA she has attempted to remove her fear of crying by allowing herself to cry (if she felt the need to). PA has found that this has resulted in her not crying in sessions. It is almost as if the fear of crying made it more likely that she would cry. For PA the boundary of thinking 'I am not allowed to cry' created added pressure and a greater likelihood of tears. PA appears to infer that the allowing herself to cry created a new boundary against her own tears.

Smith (2003b) investigated the fears of Social Workers and counsellors and found the analogy of a car was often used to represent the "fracturing of basic trust, the violation of the secure base and the uncanny" (p153). In contrast PC acknowledges the need for a healthy distance when setting emotional boundaries and uses the analogy of a helicopter. *"…you know, the way I see it is like you are with the client but also hovering above. You are like a helicopter. You in a session but you are in a helicopter above. And part of you is being objective and seeing more of an overview of the process. That sort of facilitates an emotional boundary. I think it is healthy to have that distance"* (PC, 287-92). PC identifies a fear of moving away from her professional role and either

colluding with the client or over identifying with them when not implementing the right boundaries. *"I think the therapy has to be quite healthy as well otherwise there might be an impact on boundaries because you are getting too close to the client"* (PC, L43-5). The helicopter for PC appears to represent a vehicle which she can control which sees not only the client but herself in an objective way. Unlike the analogy of a car which assumes a driver and possible passenger a helicopter hovering overhead suggests watching from a distance rather than being in the driving seat. Arguably this could be seen as having an even greater emotional distance from your client as PC attempts to upkeep a space between her and therapy 'below'. Interestingly this analogy is useful in representing PC's general approach to counselling and is discussed later in this thesis.

In contrast to other participants PD does not appear to be worried about losing control of his emotional self. His approach to boundaries appear to have developed over time to become more flexible and allow greater control and choice to the client. *"…without flexibility in your life and without some ability to operate in the grey, I think if you can't do that … as a counsellor then something is failing somewhere cause it is called humanistic therapy for some reason"* (PD, 393-5).

Defending the Self: Shame

"Yes, cause there is going to be a tinge of shame on it" (PD, L122)

Participants used boundaries to defend themselves from shame. Participants' experience of shame also influenced their ability to manage boundaries within their counselling sessions.

Nathanson (1992) argues that the shame-humiliation affect is the most dominant of all the emotions. Pathological shame can be the result of childhood abuse or neglect (Schimmenti, 2012). However, shame is also a normal part of child hood development and experience (Nathanson, 1992). The literature on shame in therapy has often focused on how clients experience and respond to shame how therapists should respond to the clients shame (e.g. Dorahy, Gorgas, Hanna and Wiingaard, 2015; Gilbert, 2010; Van Vliet, 2009) and shame in the supervisory relationship (e.g. Bilodeau, Savard and Lecomte, 2010; Kearns, 2006). There is, however, limited research which examines how therapists and counsellors respond to their own feelings of shame in therapy. This is surprising when we consider that shame can negatively impact upon empathic ability (Tangney, 1991).

Throughout the participants interviews shame was the emotion which dominated participants understanding and experience of boundaries. Shame was only mentioned directly by one participant (PD) whereas it was highlighted by other participants when describing their response to boundary issues.

Nathanson writes that shame affect is "a highly painful mechanism that operates to pull the organism away from whatever might interest it or make it content" (p138). Nathanson's has a broad definition of shame which includes experiences of shyness, guilt; embarrassment or humiliation. However, more specific examples of participants experiencing the shame affect can be found throughout the interviews that fits into Lewis (2003) phenomenological description of shame. That is: the desire to hide or disappear; feelings of intense pain, discomfort, or anger; feelings of inadequacy or unworthiness; and becoming the object in addition to the subject of shame.

Shame is "a boundary phenomenon that is present in the relationship between two people when one of them 'feels seen' in a particular way" (Kearns, 2006, loc 2176). Therefore experiences of shame often turn the focus on 'self' rather than on 'other' (Kearns, 2006). However, Kearns argues that it can also be an "intensely personal and painful experience of connectedness to 'other'" (Kearns, 2006, loc 2199) or the projection onto the other. When considered in the context of therapy either experience will change the dynamic of the relationship between counsellor and client.

The participants experience of shame often related to some form of 'moral failure', that is a failure to be "honest, trustworthy, or fair" (Gausel and Leach, 2011, p468). However, rather than experience shame because of moral failure the participants attempted to avoid shame by avoiding the potential for moral failure. Gausel and Leach suggest that moral failure is linked to the experience of shame and can result in motivation for self-defence or self-improvement depending on the whether the person is concerned with the impact on their self-image versus their social-image. Participants protected themselves from experiencing shame by, for example, not charging clients for missed sessions or not allowing feelings of attraction from the client to be expressed in the counselling sessions. In these instances the counsellor was attempting to *stop* a moral failure from happening. The threat in this instance is the potential feelings of shame as a result of moral failure. Participants used boundaries to protect themselves from this possibility. However, the potential moral failure was often related to the counsellors own values, fears and worries rather than the needs of the client.

Similarly to their reactions to fear, participants often used boundaries to protect or shield themselves from experiencing the shame affect. This is another example of the amoeba principle in action. This is unsurprising when we consider that shame can

often impact on our very sense of self (Nathanson, 1992). For participants in this study their shame could often be masqueraded as fear.

The following section considers examples of participants shame and how this related to boundaries, and defending the self.

Personal versus Professional Shame

Participants identified both their personal and their professional shame as an influence on their management of boundaries (PA, PB, PC, PD, PE, PF, and PG). Participants shared feelings of shame which echoed Nathanson's (1992) dual classification of shame that is innate feelings of shame and social shame learnt through social interactions. Innate shame related to the participants own personal experiences outside of therapy. For example, PC identified the impact of her religious beliefs on her experience of shame and boundaries, whereas PD identified the influence of an old boss on his understanding of right and wrong (these examples are explored in much more detail in other sections of this thesis).

Social shame related to the participants feelings around being judged as a professional counsellor or therapist. For example, PB identified about her fear of judgement from her peers, and PD talked about the judgement of an official investigation and inquiry.

Henderson (2006) argues that psychotherapists (Henderson refers to analytical psychotherapist but one assumes that he refers to all psychotherapists) experience shame on both the affective and social level, but adds a third dimension, arguing that they also experience it epistemologically. That is an experience of shame which impacts on the therapists sense of knowledge. The extent of participants' experience

of shame throughout the interviews suggests that these counsellors also experience shame at this deeper level as it greatly influenced their practice, in particular surrounding boundaries. This similarity existed despite the obvious differences in training and experience between counsellors and analytical psychotherapists.

Henderson (2006) also argues that there is an inherent shame in being a psychotherapist and that part of a developing a "secure therapeutic identity" (p327) for therapists means living with this shame. Barnett's (2007) small study found shame to be a key aspect of psychotherapist histories and found early experiences of shame may result in patterns of self-sacrificing behaviour in therapy. For Barnett it is these patterns which can result in the therapist aiming for clients to see them as "idealized parental figures" (p267). Barnett suggests that this can lead to therapists overvaluing themselves and focusing all that is bad towards the client. Whereas Epstein (1994) argues that therapists who create maladaptive defences against shame can often be narcissistic and can therefore often play a role in boundary violations.

It is unclear if participants of this study had shame as a key aspect of their personal histories as this was largely unexplored within the interviews. Shame did play a part in participants' professional histories. Some participants did share experiences of self-sacrificing behaviour towards clients. PG evidenced a particular struggle with boundaries when responding to clients who were particularly 'needy' or in hopeless situations. For PG this response to clients is led by shame. PG cannot bring herself to say 'no' to the needs of those types of clients. *"I know something about myself, if somebody was in need, I would never say 'no'"* (PG, L627-628).

PG describes how this would be particularly difficult if she worked in private practice and wonders if that is why she hasn't chosen this route for her career. *"…maybe that's*

why I choose to work here, because it doesn't kind of affect me that way. I think if I worked from home, in private practice, it would test me" (PG, L639-641). PG appears to have avoided private practice for fear of being able to uphold boundaries. Could PG be responding with a narcissistic need as Barnett suggests? Initially, I felt that it was the client's need which motivated PG. However, further investigation suggests that it is actually *her* need which motivates her to break those boundaries. *"**I couldn't be that person** who didn't respond in their hour of need. I know that. Whatever time that was"* (PG, L636-637). PG suggests that being 'that person' who didn't respond to a client in need is shameful and infers that there would be a level of guilt by not responding. Therefore, PG admits that she would respond whether there was a breaking of a boundary or not. This does suggest a level of narcissistic need as described by Barnett as PG did not want to be viewed by the client as 'that person'.

However, PG advises us that she can respond similarly in her personal life. *"I struggle when someone becomes very needy of me. And when that neediness kind of spills over to kind of consume the relationship, and I`ve had friendships were that's happened. The friendship, the relationship has really been about this other person"* (PG, L252-255). Suggesting that for PG the impact of shame is the same whether she is responding personally or professionally. PG has decided to live with this shame and deal with the consequences. It is arguable, however, whether PG has incorporated shame as part of a 'secure therapeutic identity' as described by Henderson (2006). PG acknowledges it and accepts it, but it appears to have an unhealthy influence on her practice which PG herself acknowledges. PG evidences her shame of this through her reluctance and embarrassment of sharing her experiences with the researcher. *"Well there is another one that I`m saying to you now, about a phone number, that I`ve*

lied to you, that I have done that. And I did again, look at me I`m embarrassed now" (PG, L573-5).

Interestingly, Barnett's idea of an 'idealised parent' manifests itself in PD's interview. However, this is not in relation to PD wanting clients to see him that way. Indeed, PD appears to place his original counselling tutor in this role. *"So if you do something in counselling that you wouldn't want to tell your original tutor, it is likely to be wrong"* (PD, L119-20). Interestingly, PD tries to avoid a stance of idealised parent in his own role as supervisor. *"I think a gentle philosophic approach to supervision which is deeply respectful of the relationship, means that you can really talk about anything, and you can really get into boundaries, and ethical behaviour without causing any distress and without seeming to be judgemental and not ever straying into that relationship that can happen with a supervisor, or pupil and teacher or pupil and headmaster. Or villain and detective*" (PD, L255-60). Neither does PD see this as his role in counselling clients. *"Well I am not sure there is much role for me doing that in a counselling role as a client, unless there is a clear overstep but I think more … it comes into the work more as a supervisor, because you want your supervisees to develop into being the best counsellors they possibly can*" (PD, L246-9). This suggests that PD sees shame as part of his professional practice (i.e. anything that would be deemed shameful to his original tutor is not used) which influences his use of boundaries. Suggesting that PD's uses social shame as a tool to monitor his own practice. *"That is a not bad rule of thumb"* (PD, L118-9). However, PD also infers that this is somehow linked to his own innate shame as he links the experience to that of being parented as a child. *"I remember asking a boss of mine once when I was about 21, 'how do you judge what is right and wrong?' and he said 'I tell you this lad, if it is something you won't tell your mum about then it is wrong' and I carried that with me*

all these years. Do you know what? That is not bad" (PD, L115-18). Interestingly, the use of shame to monitor his use of boundaries is also a part of PD's identity as a professional; where the line of acceptable and unacceptable practice is drawn via the values drawn from his original tutor. In contrast to this PD does not appear to use overt shame in his supervisory capacity towards his supervisees but by offering moments of reflection in the supervisory relationship can invoke shame. *"Yes I have said to somebody 'just stop there, I want you repeat what you said and listen to yourself very carefully' and before they start to speak they think 'oh'"* (PD, L228-30).

Shame from Charging

Charging clients for counselling sessions. It is discussed in detail by three participants - C, D and F and shows various aspects of the shame-affect.

Gray (1994) highlights how varying the therapeutic frame by altering terms of payment with clients should indicate to the therapist a need to consider the feelings that have been aroused about themselves and their clients. Henderson (2006) argues that therapists can feel shame surrounding charging fees for a variety of reasons, such as client neediness or because the therapist found work with that client particularly rewarding. Kearns (2011) argues that the therapy profession experiences collective shame about charging clients. Kearns argues that this is the result of a welfare state and free NHS services but also because of the profession does not take itself seriously. Participants had varying reasons why they felt shameful about charging clients. PF felt potentially shamed from God for charging for her services. Whereas, PC had a general sense of embarrassment about asking for missed payments. Conversely, PD's felt that charging for his services was nothing to be ashamed of. Each example will be discussed in turn.

PC works in private practice, and charges for her sessions with clients. PC asks for 24 hour notice if a client cannot attend the session. However, PC finds the idea of asking for payment from a client when they have not attended a session extremely uncomfortable.

"It is hard the issue of money. I feel a bit easy in asking them to pay for a session they didn't have. But I do encourage ... I do say 'I would really appreciate 24 hours notice' and most people do really. I think there are a couple of people who haven't. And one occasion my client just gave me the money, but I didn't ask her for it. I don't think I would have been able to actually ask her for the money for the missed session. So that is like a boundary issue. It could be. I find that a bit of a challenge for me."

(PC, L257-8)

In this example, PC is sharing an experience of shame as defined by Lewis. PC has the wish to: hide from the client with regard to this issue ("I don't think I would have been able to actually ask her for the money for the missed sessions"); has feelings of discomfort ("I feel a bit [un]easy in asking them for a session they didn't have"); has feelings of unworthiness regarding the value of her time as she feels uncomfortable charging for missed sessions. Arguably, PC would feel the object of shame (i.e. felt herself to be the person who shamefully asked for payment) in addition to the subject of shame (the person who experienced shame for requesting the payment).

The challenge for PC appears to be her uncomfortable feelings about asking for payment, the interview does not explore these feelings. However, it is easy to suggest potential reasons for this e.g. fear of a negative reaction from the client, fear of judgement about the participants motivations being monetarily based etc. PC does identify that this particular issue is about control, and links this to boundaries.

"I suppose the reason that it came to mind as a boundary is I suppose it is about ... a little bit about control as well and control is very much about boundaries. At the end of the day it is my job and my income"

(PC, L279-82)

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Interestingly, what PC is talking about is a lack of control surrounding collection of payment from her clients. PC relies on this money for her income. Even if the client does not turn up for a session PC will be unable to use that time for another client. PC reacts to the shameful feelings of asking for payment for missed sessions through avoidance. PC is unable to ask for the money for the missed payment because she does not want to feel the shame-affect. Therefore, she avoids this issue completely, and admits that she could never actually ask for it. PC sits back and hopes that clients would willingly offer some money for the session. Effectively evading the issue.

In another example, PF describes how her original motivation for training to be a counsellor made it difficult for her to initially charge her clients.

"P-Yes, because I hadn't started it in the first place that I was going to
I-For that reason
P-For that reason, that I was going to be paid for it, you know what I mean, it was, I started it because of what I was doing in the Church, of listening to people"

(PF, L220-4)

Again, PF is describing shame as described by Lewis. PF did not want to be seen as charging for her sessions, and felt uncomfortable about it. Initially, PF felt unworthy for charging for her time, until she accepted that she had completed courses which had cost her money and many years of training. Arguably, PF's experience of shame (or predicted experience) is that she would somehow be judged by God if she took payment for client work instead of doing it voluntarily. *"…it was something about, offering the love of God, to people and the way that I could offer the love of God to people was actually listening to them"* (PF, L271-273). Therefore becoming the object of shame rather than just experiencing it.

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PF was uncomfortable with charging her clients, as if somehow it reflected badly on her. Interestingly, when PF worked in other settings she was much more comfortable to be paid for her practice as long as the payment was not coming directly from the client. *""You know, that kind of difference, I was kind of, more comfortable thinking that the people weren't paying, of course they were but …"* (PF, L203-4).

This statement is important because it underlines an important aspect of this participant's boundary management that is an avoidance of discomfort of shame within her sessions. Discomfort in this sense is the reluctance to ask clients for payment. The reason for this is PF's concern that asking for payment is somehow reflecting a monetary motivation for her counselling. It is only when PF decides that she deserves payment because of the hard work and training that she has completed that she becomes comfortable in asking her clients for payment.

PF's reaction to this shame-affect can be understood from Nathan's (1992) Compass of Shame model which identifies various ways individuals can respond to experiences of shame. Similarly to PC there is an element of avoidance of asking clients for payments. Nathanson argues that avoidance is characterised by a slow movement away from that which causes the shame-affect. Interestingly, PF appears to describe her experience in the opposite direction. That is, PF starts her counselling career with the complete avoidance of payment from clients, but slowly over time PF moves closer to justifying why she should be paid, and therefore her shame-affect reduces.

In contrast, PD describes how he has always been completely comfortable in asking for a payment from his clients. PD does identify that he has been flexible when asking for money but that he has no doubts that this is something he is entitled to do.

"Wasn't there a debate last year in a magazine about the whole moral wraparound of being paid and taking money off of people as a counsellor. Well for me it is no different … like I do now, whatever I do in supervision, and counselling, I have closed my business down, I am not looking for payment anymore, I chose to do it pro bono. But when I had the business working from here I chose to do it for reward. I never charged what other people charged because I chose not to, but I never felt a tinge or remorse, guilt or reluctance about taking a fee because it was a service delivered"

(PD, L348-56)

PD argues that his experience of charging for sessions is completely free from the shame-affect. PD does not at any point report that: he wishes to hide or disappear from discussing this topic with clients; he does not feel uncomfortable ('I never felt a tinge of remorse, guilt or reluctance'); and he feels validated in what he offers clients ('it was a service delivered'). Interestingly, PD describes how he did not charge the same amount as other counsellors, suggesting that PD charged less than the average rate. There could be many reasons for this, one of these may be a reluctance to appear to clients as money orientated, and thus feel shame. However, it could just as easily be reasons unrelated to the shame-affect such as a business decision to use lower fees to attract clients. PD is aware of the issue, has reflected on it and acts with confidence when following that decision through to its end. PD appears to follow Freud's (1913) view that therapists should "cast off false shame" (p131) when charging for their services.

Shame of Attraction

Attraction between counsellor and client is another example of a boundary issue which induces the shame-affect in some of the participants of this study (PC, PB, and PD). Mann (2015) argues that majority of therapists have an instinctive wish to avoid discussing the erotic in therapy. This, Mann argues, is a form of self-protection which

works towards keeping the status quo. Mollon (2005) states that "because sexuality is threatening and frightening, it is repressed or banished from discourse" (Mollon, 2005, p167-8). Shame and embarrassment can be felt by therapists who encounter sexual attraction within therapy (Rodgers, 2011). Certainly, some participants of this study were uncomfortable in exploring potential issues of attraction with clients and aimed to protect themselves from feelings of shame. Shame may be felt by therapists who feel inadequately prepared to work with the sexual in therapy (Kearns, 2011). Whereas therapists may also be fearful of unethical practice, if they engage with the erotic in therapy, through a lack of competence in that area (Rodgers, 2011).

PD is the only participant who refers to the boundary issue of client/counsellor attraction directly. PD identified endings with clients as a way of protecting himself from any possible sexual advances from them. This could be argued to be an example of the withdrawal response to shame as identified by Nathanson (1992) and is triggered through the shame of possible client/counsellor attraction.

"Of course, clients cross boundaries too. I say now regularly in supervision, as counsellors, you have to be aware and monitor this closely the demeanour of clients as your sessions roll on. Particularly if it is male and female because it is a hugely intimate relationship but there is a boundary there, it is a professional relationship. Yes it is very intimate. But clients will often read the message wrong and start to build up an emotional response to you as the counsellor which starts to drift into inappropriateness. That is often displayed in dress, grooming and demeanour. To stop the client crossing that boundary the counsellor has a responsibility to do something and for me when I started to learn about good endings, that is when I realised there is a way to deal with it. Once somebody starts to behave in a way like that, their confidence is back, they are believing in themselves, they are dressing confidently, and grooming themselves, so there is an ending in sight. So you bring your counselling to a close. At satisfactory ending without anybody crossing a boundary. Now you talk about experience but that didn't come to me without working with one or two people who were about to cross that boundary otherwise why would I think about it."

(PD, L203-21)

PD relates his use of endings as a way of protecting the client from doing anything inappropriate, and crossing a boundary. Presumably, this means preventing the client acting on their feelings of attraction to the therapist. However, it is unclear if these feelings are actually there, because they are never apparently addressed or explored.

PD appears to make an assumption about this attraction, and relates it to therapeutic outcome. PD hypothesises that because the client takes a greater pride in their appearance this may be dually associated with both therapist attraction from the client and evidence that the therapy has been successful.

Point of reflection: Interestingly, this is explained in the context of therapy with female clients, rather than male, which indicates PD may presume heterosexual tendencies in his clients. Rodgers (2011) suggests that research should be expanded to investigate the various combinations of sexual orientation between therapist and client to give a greater understanding of the erotic in therapy.

If we explore PD's account further there is some indication that his response is related to the shame-affect.

> *"I have had conversations with three lady counsellors who have had boundaries seriously crossed in terms of sexuality. Some have been absolutely outrageous and others have been very creepy"*
>
> *(PD, L299-301)*

> *"Was one an absolutely, sit in a chair after about six sessions he said 'I am married', 'well, that is what an affair is' and that was after six sessions so … that is a massive, it is the biggest boundary isn't it. That is massive. And she had to deal with it and she did. The creepy one was … 'have I ever told you how nice your legs look in those shoes?', well this poor lady freaked out, cause it was so kind of covert. What she said to me was that made me think 'what is he thinking? What is going through his mind in the hours we have been together?'"*
>
> *(PD, L307-14)*

"She was flummoxed and it was a difficult one for her. She carried on for another couple of sessions but she couldn't do it cause of worrying about what he was thinking. That kind of boundary is similar to the one where I can see a non-professional attraction growing in a female client and I bring it to an end. But that is kind of … it is not a big fracture if you do it properly. But when someone actually says … 'can we have an affair?'"

(PD, L316-22)

PD links these female counsellors experience with his own. Their stories certainly reflect an element of shame as these therapists are asked directly or indirectly to participate in a sexual relationship or flirtation with their client. It appears that PD associates shame with his experiences also. Considering Lewis phenomenological description of shame we can see similarities. PD wishes to escape away from the therapy with these clients and has clear discomfort in continuing therapy with clients who may have a sexual attraction towards him. Furthermore, PD may be experiencing some level of shame at the thought of the client crossing that boundary, but is protecting himself from being the object of that shame by removing the possibility of that happening. This is a thickening of boundaries as per the amoeba principle.

If we relate this to the Nathanson's model, we can label PD's reaction as a withdrawal response. PD withdraws himself (and the client) from the therapy process. PD argues this is for the protection of the client. However, without assessing the accuracy of his assumptions with the client the counsellor has no way of knowing if what he is feeling is correct. Therefore, instead PD may actually be protecting himself from feeling the shame-affect. When PD states that *"…it is not a big fracture if you do it properly"* (PD, L320-21) he can be referring to both the client and himself. Arguably, this example of withdrawing from therapy, and ending the sessions is also illustrative of the Amoeba Principle, because the participant is protecting himself by firming up his boundaries through the creation of distance and space between himself and the client.

PD was the only participant to mention counsellor/client attraction directly. However, other participants commented on the male/female dynamics in therapy evidencing an anxiety around potential attraction in therapy underpinned by shame.

"But 99% of my clients have been female anyway. So that isn't an issue for me. I do now have more male clients. But I haven't found it an issue except there is somebody in the last session, one of my male clients who is going through some difficulties in his relationship, he started asking what I was doing for Christmas. And I did feel slightly uncomfortable about it. That is a boundary for me. I did tell him but I didn't go into any kind of detail. But to me that would be a bit of a ... not a red light ..."

(PC, L87-94)

Throughout her interview PC is keen to ensure the researcher knows that she does not have an issue with boundaries in her practice. In this example PC advises us that client/counsellor attraction is not an issue because of the ratio of female to male clients in her practice. Despite this PC has discomfort about one of her male clients and his inquiries about her plans during the Christmas period. This discomfort seems to be fuelled by the fact that the client is having relationship difficulties. Shame in this example is actually reflected in PC's reluctance to discuss this issue further with the researcher. Interestingly, PC's use of the term 'red light' suggests a fear of possible client attraction as she sees his questions as a possible warning signal. Although PC wavers in her use of this term as she struggles to find the right expression – '**not** a red light'. PC appears to protect herself from the client's queries through giving minimal detail to the client and avoiding discussing details that she was uncomfortable sharing.

PC appears to link, on some level (possibly unconsciously), the clients questioning of her own Christmas plans as a possible indicator of attraction. PC aims to avoid the shame of an interaction which may bring the clients attraction into the conscious awareness of the therapeutic relationship. Thus, protecting herself from experiencing shame in effect thickening her boundaries. *"That is a boundary for me"* (PC, L92).

PB has a similar level of discomfort after she reflects about a moment of physical touch between her and a male client.

"it felt ok although I took it to supervision but still there is that thing in your head – have you crossed that boundary? Although it wasn't me who initiated it, so again very difficult, and you know female/male – that was a female/male situation, would it feel uncomfortable I always think if it was a female? Because no female has ever done that"

(PB, L30-35)

Interestingly, PB does not feel this at the initial moment of the interaction but at a later date once she has reflected about it. Furthermore, PB directs her focus on herself, as she questions whether *she* has crossed 'that boundary'. PB ponders over the difference between male and female touch from clients and if her response would be different for each. However, PB has nothing to compare it to and so struggles to conclude if indeed a boundary has been crossed. PB indicates that she may be feeling shame in response to this experience although a certain level of uncertainty exists as PB wrestles with the notion of where the boundary line lies. PB cannot decide if it is set by her – 'it felt ok', 'have you crossed that boundary?'; the client – 'Although it wasn't me who initiated it'; or the profession – 'I took it to supervision'.

In Rodgers (2011) study of therapists' experience of erotic transference some of the participants found that by experiencing the erotic in the therapeutic relationship that it increased their self-awareness and therefore gave them a greater understanding of their own boundaries. Arguably, this is the same for these participants although each participant's experience also appears to have also raised their fears and anxieties surrounding boundaries.

Judgement from Peers

As previously identified participants were fearful of being judged by their peers and this was effectively participants being afraid of being shamed in front of their peers (PA, PB, PC, PD, PE, and PG).

Shame is inevitable in therapist training (Kearns, 2006) as trainees are effectively judged by their tutors, supervisors and peers.

PE experienced shame during her training as she felt judged by others on her course as she veered from the boundary norms. *"It felt a bit difficult because, it felt almost as though they'd decided before they'd heard. And that actually there wasn't there wasn't an understanding of how that was going to help in the relationship"* (PE, L355-357).

PD felt that any judgement of peers should be done with compassion because counsellors were unable to know all the facts when making judgements in their practice. *"So although boundaries are absolutely vital, but I think when we judge people, our peers and supervisees in terms of boundaries we have got to be forgiving as well"* (PD, L135-7). PD appears to argue that counsellors make mistakes with boundaries and therefore should not be judged too harshly. This is to limit their experience of shame. PD expresses this view in terms of judging others whereas he could just as easily be talking about his own practice.

PG withholds information about her boundary breaking with her employer on one issue (taking a client out for an ice-cream) but not another (breaking confidentiality). Interestingly PG believes that both of these interventions were in the client's interest and justifiable in her practice. However, only one was disclosed or shared. This appears to be because the breaking of confidentiality is an acceptable form of boundary breaking because it was part of safeguarding the client. In contrast taking a

client out for an ice-cream is potentially less acceptable to peers and therefore could result in experiences of shame for PG in breaking this boundary. The difference in disclosure appears to be related to avoiding then shame affect rather than the client's interest. Although PG does not appear to have done anything which endangers the client in any way and has reasons to justify her actions she appears to be fearful of others finding out about this broken rule.

PC's appeared to be generally apprehensive about my questions during the interview and 'getting it right'. PG worried how other participants had answered the questions and appeared concerned she was giving me the right answer. *"What did others say about this?"* (PG, L416). Whereas PA was concerned about if she made any disclosure about boundaries that might may be judged to be dangerous or incorrect and asked me what I would do with that information. These participants appeared to be fearful of being judged or shamed in front of others by expressing a wrong or incorrect view or intervention to do with boundaries in their interviews.

Summary

Participants understanding and experience of shame was important in their management of boundaries in therapy because it influenced how these counsellors responded to boundary issues, specifically their responses were often aimed to protect themselves. The shame affect may be the counsellor's response against the threat of exposing the self to others. However, participants' reaction to boundary issues may also endeavour to protect them from the threat of experiencing shame itself. Shame also influenced the level of openness that the participants had when tackling boundary issues.

Establishing Self

***"Well I think I have just learnt what self is, I think I have learnt who I am, and
what isn't my stuff" (PA, L457-458).***

Participants identified the importance of boundaries for *Establishing Self*. In contrast
to defending themselves participants used boundaries to establish their own identity
both professionally and personally. This meant establishing who they were both
physically (i.e. their physical presence in sessions) and their values (i.e. what they
brought to counselling practice). .

Participants found that using boundaries to *Establish Self* offered a form of protection.
*"…without them it would be a mess, it would be very messy (slight laughing), I would
be a nervous wreck and completely depressed, and (laugh)"* (PA, L831-833).

This theme can be split down into smaller themes which are: *Establishing Role*;
Confidence in Practice (Feelings of Competence); *Separating Counsellor from Client*;
and *Comfortableness of Counsellor*.

Establishing Self: Establishing Role

"To be honest the guidance from that is what helps me with fulfil each role"

(PA, L555-6)

Establishing their Role was an important aspect of participants' experience of
boundaries (PA, PB, PC, PD, PE, PF and PG).

Participants' use of boundaries to establish the scope of their counselling role can be
compared to Ashforth, Kreiner, & Fugate's (2008) description 'role boundary' in
boundary theory. This included how they used boundaries to understand the role

themselves. *"And actually, you can't that's not your role, and that's not your place, and, erm yeah, you have to remind yourself of that, every now and again"* (PA, L1016-1017*). "…from where I am sitting I don't see that as my role in terms of counselling"* (PF, L483-484). But it also included using boundaries to define their role with clients (Kent, 2013). *"…so one thing that we talk about at the very beginning of the contract is that my role within the counselling"* (PG, L53-55).

Despite participants describing how boundaries impacted on the different roles that they did, they did not describe what Ashforth, Kreiner, & Fugate call boundary transitions (that is the boundary elements that made up these transitions). However, they did describe how boundaries where used to separate both their personal and professional lives as well as distinguishing between their other professional roles. This was important in establishing their professional self.

Some participants reported that the boundaries taught via their counsellor training actually helped them establish boundaries in their other roles. *"To be honest the guidance from that is what helps me with fulfil each role"* (PA, L555-556). *"I think possibly it's the other way round, actually that some of the things that I have learnt in counselling about boundaries that I might possibly take into spiritual direction"* (PE, L404-406). This established a greater sense of identity for participants in each of the roles that they held. It also meant participants could focus on the specific task of their role. *"I think I have got three roles, my personal life, my nursing role, and my counselling role, and my boundaries have to be very definitive in that, because I can't secretly counsel my patients, which could be very tempting when you are using your skills to talk with someone"* (PA, L541-544).

By establishing their role participants also protected themselves from the uncertainty of an unbounded experience. *"It is for the client and then there isn't an expectation beyond that for them to impact on your time or anything like that"* (PC, L22-24). *"That's wrong, and that I`m taking on something that I shouldn't be taking, so again it is keeping yourself safe"* (PB, L525-526).

Using boundaries to establish their role with clients was important to participants. However, it also included establishing the counsellor's professional self or professional identity. Establishing their professional role meant that participants could protect themselves from a variety of potential threats which I have identified earlier such as the potential for client complaint, or peer/professional judgement from colleagues as they adhered to the rules of the counselling role. *"Boundaries are what keep us on the straight and narrow and keep us able to justify everything that we do in our client work"* (PD, L11-2).

Establishing Self: Confidence in Practice (Feelings of Competence)

"…at the beginning that was really quite uncomfortable, to be fair, until, you know what I mean, it was probably a confidence thing"

(PF, L237-8)

Participants identified *Confidence in Practice* as an important aspect of managing boundaries within sessions (PA, PB, PC, PE, and PF). Hermansson (1997) highlights the need for counsellors to develop their own 'professional judgement and competence' (p143) as key components of responsible boundary management.

Participants identified confidence in their practice as an important aspect of being able to manage boundaries effectively. This contributed towards establishing their professional self. *"Yeah, yeah and confidence, I think it is a confidence issue as well, I think as I have grown, erm, in my confidence to try out certain things, and seen it work so well it just makes it easier to do it...to try it again"* (PA, L237-8). Participants' feelings of confidence were often related to feelings of competence in their role. *"…it gives you confidence, supervision"* (PB, L764). *"…so in a lot of ways supervision has been reassuring that you're on the right path"* (PB, L768-9).

Participants (PA, PB, PD, PE, PF, and PG) also described a developing sense of confidence in role which developed over time through their training. *"I think the more structured you are at the beginning the more you can relax in the session, 'cause you know they're there, and the more you practice it, which sounds awful doesn't it that you are practicing on people, but you are really, when you first out of counselling from your diploma, you are so diff...well I was... so green to it, and scared of going into the situation really, and it is not until things start to work and you see people... benefiting really, from those sessions that you start to relax"* (PA, L787-93). *"The training enables you to put labels on things"* (PD, L104). *"…you realise that and you know, because those issues have come up in your training"* (PB, L1113-4).

Participants' feelings of confidence and competence impacted upon how they responded to boundary issues. Often, greater confidence lead to participants implementing firmer boundaries in response to boundary issues. Examples include PF implementing firmer boundaries after she had been given permission to do so by a trusted mentor (although this was before her counsellor training).

Research suggests that therapists develop a greater sense of competence and competence in boundary issues as they gained greater experience over their career (Ronnestad & Skovholt, 2003; Skovholt & Ronnestad, 1995). However, this study suggested that these participants gained greater confidence in dealing with boundary issues through experience of dealing with them (either in their personal or private life). The competence with which they dealt with boundary issues is hard to judge as we do not know the experience of the client in each case. However, participants felt as if they became more competent in dealing with boundary issues after each experience. For example PD dealing with client attraction in sessions or PA dealing with the threat of physical violence. For PE this also included moving from a theoretical understanding of boundaries through to the practical application. *"Yeah, I guess it has, it's definitely developed because it can move from sort of theory, into how does it actually pan out with different people. So it definitely does change"* (PE, L271-3).

Conversely, some participants suggested a lack of confidence in their interviews surrounding some boundary issues. Again, this was often related to how participants perceived their competence with that particular issue. For example the issue of the erotic or sexual in therapy mentioned earlier (PC, PB and PD). Sometimes participants identified these feelings directly. *"…well I was... so green to it, and scared of going into the situation really"* (PA, L791-2). However, often they were expressed much more covertly. *"All the professionals just won't do it. The reason I think it is good, and it is a challenge for me, is that it just doesn't give that client that feeling of knowing where they are"* (PC, L219-22). These could be labelled feelings of incompetence.

Feelings of incompetence is a phenomena which has been explored within the research literature (e.g. Thériault and Gazzola, 2005; Thériault, Gazzola and Richardson, 2009). Feelings of incompetence can be defined as "moments where a

therapist's belief in his or her ability, judgement and/or effectiveness is diminished, reduced, or challenged internally" (Thériault and Gazzola, 2005, p12). They appear in both novice (Thériault, Gazzola and Richardson, 2009) and experienced therapists (Thériault and Gazzola, 2005). Feelings of incompetence influence the development of the therapists professional-self (Thériault and Gazzola, 2010). The majority of this research has been focused on clinical and counselling psychologists. However, the findings are still pertinent to this discussion.

Thériault and Gazzola (2006) argue that feelings of incompetence in therapists are common, yet they are often kept underground through embarrassment. Thériault, Gazzola and Richardson (2009) found that novice counsellors avoided sharing feelings of incompetence with supervisors because they do not want negative evaluations of their practice and therefore the subject then becomes 'taboo'. They secretly held fears about their competency. Thériault et al (2009) identified this as a self-protective response which they labelled 'showing them the good stuff'.

Arguably then, it is the shame affect that causes feelings of incompetence. Nathanson says "I suspect that shame produces a sense of an incompetent self, that there is a part of the self created by shame" [italics original authors] (p211, Nathanson, 1992). Although the shame affect is not caused by incompetence it can produce, in those experiencing, feelings of an 'incompetent self' (Nathanson, 1992, p211). Participants identified that they have feelings of incompetence, including ones underpinned by shame. "*I feel a bit [un]easy in asking them*" (PC, 257-8). Participants often wanted to protect themselves from these feelings and aimed to avoid boundary issues or withdraw from the experience to reduce the feeling of this affect as detailed earlier.

Research suggests that some boundaries (such as those between work and home life) can become more permeable when novice counsellors have feeling of incompetence in their practice (Thériault, Gazzola and Richardson, 2009). Whereas Thériault and Gazzola (2006) found that the setting of clear boundaries at the start of therapy led to reduced feelings of incompetence for the therapist. Therefore, the closer these therapists linked the responsibility of client change to themselves rather than to the client the more likely they were to have feelings of incompetence.

PC offers a good examples of how confidence and feelings of competence (or incompetence) can impact on boundary management in sessions. PC appears on one level to have a firmer level of confidence with her practice, and in particular when managing boundaries. For PC boundaries are, for the most part, the same for each client and session. PC infers that she is confident in her practice and her use of boundaries in the way she appears not to question them, referring to them as *"always the same really"* (PC, L324). Despite this PC does infer a lack of confidence in some of her practice when asserting herself with some boundary issues. For example when asking a client to remove their shoes, *"I couldn't bring myself to say 'would you mind taking your shoes off?' so ... there was me barefoot and he was probably going 'oh she is a counsellor'"* (PC, L352-4) and when charging clients for late payments. *"I feel a bit [un]easy in asking them"* (PC, L257-8). PC does not appear to see these as boundary issues. Furthermore, PC acknowledges her limitations when trying to manage time boundaries in her practice. *"And I know that isn't very good on boundaries. So that is a challenge for me"* (PC, L210-1). PC sees this aspect of her practice as unprofessional and doubts her ability to manage this effectively. This suggests PC has feelings of incompetence surrounding this issue (i.e. she doubts her ability). Furthermore, these feelings impact on how she responds to this issue.

Establishing Self: Separating Counsellor from Client

"*I know that's not me*" (PE, L470-471)

Separating the Counsellor from the Client was an important aspect of most participants experience and understanding of boundaries (PA, PB, PC, PE, PF, and PG). Participants described the importance of using boundaries to distinguish between themselves and the client. This was often a form of protection for themselves.

PC describes this separateness as a type of distance between client and counsellor. *"I suppose I mean coming alongside someone and helping them with their issues and it is about maintaining some kind of healthy distance between yourself and the client so you don't merge, there shouldn't be a merging of where you are at, really"* (PC, L13-16). The word 'merge' here is significant as participants identified various ways that they could fuse with their clients, and how they used boundaries to stop this from happening. For PC it was important to be objective and almost hold herself back from what was going on with the client. *"…you know, the way I see it is like you are with the client but also hovering above. You are like a helicopter. You in a session but you are in a helicopter above. And part of you is being objective and seeing more of an overview of the process. That sort of facilitates an emotional boundary. I think it is healthy to have that distance"* (PC, L287-292). The reference to hovering like a helicopter emphasises the objectivity that PC is describing with clients. That works as an emotional boundary between her and the client. Interestingly it almost suggests that PC is watching the process rather than part of it. Although she tempers this point by acknowledging that there is only 'part' of her that has this objectivity. PC's metaphor

suggests that she holds herself at a point of safety, away from the client, so that she can see the client but also the process that they are in.

PA felt that it was important to acknowledge the separateness of herself to the client to protect herself from being too emotionally attached to the client. *"…protection of self again, I suppose sanity, (laughs)"* (PA, L1007). PA identified how she tried to protect herself from creating client dependence by 'letting go' of her past clients and acknowledging that they can live their lives without her. Interestingly, PA does not identify protection of the client here, but protection of herself. The laugh by PA is an attempt to mitigate the word 'sanity' from any serious conviction that PA was protecting her actual sanity. However, PA's strict and firm use of boundaries in her interview indicates that establishing herself as separate from her client was extremely important in managing the stability of her mind.

Similarly, PE identifies how her anxieties are heightened when she experiences 'breached' boundaries between herself and the client. For PE this breach is due to the physical and emotional presentation of the client. *"And so the boundaries somehow are breached, and it's really hard then and I can remember one time I was really struggling to keep awake and this client had numbed herself down so completely that I was feeling it as well you know. It's contagious"* (PE, L455-457). The use of the words 'breached', 'struggling' and 'contagious' all suggest an unpleasant experience for PE. These words are associated with an attack. In this case the attack comes from the client towards the counsellor, although not purposefully so. Any form of attack usually warrants a defensive response. PE identifies how she struggles to differentiate the clients experience from her own. To defend against this PE needs to acknowledge herself as separate from her client. Therefore, PE aims to establish what is self before

her sessions and does this by focusing on her own physical presence. PE does this through going for a walk.

"The walk grounds me, so I know I feel the air I go through a thing, what can I see, I can, what can I hear what can I feel and I'm grounded and I'm like ok how am I feeling today what is it that's in me so when I go into the counselling room if there's things that have been passed backwards and forwards I know what's me and I know what's them"

(PE, L476-480)

For PE, the walk is an experience which focuses her on what is and is not *her*. Arguably, this is a firming of her boundaries as she clearly focuses on what is coming from the client rather than her own self. Although PE argues that this is beneficial for the therapeutic process and the client, she also identifies that it reduces her own anxieties in sessions. Thus, it is also a form of self-protection.

The importance of using boundaries to distinguish between client and counsellor is most apparent for some participants when discussing the issue of grief. PB explains how her own grief impacted on her sessions with one client. PB began to identify *"very powerful parallels with parts of my life"* (PB, L1281-1282) between herself and the client. PB acknowledged the need to keep her grief away from the client's therapeutic process. *"…that was a boundary I kept, not revealing!"* (PB, L1262-1263). However, PB highlights how it still had an impact. *"I said "I don't know if you noticed, but in our first few sessions I found it quite difficult?" I had got quite upset when she talked about losing her husband"* (PB, L1238-1240). Interestingly PB's use of boundaries separated her own experience from the clients thus protecting the therapeutic process. *"…you know we were both suffering a bereavement but again you can't bring your stuff…and that's a boundary, you cannot bring your stuff into the room because it influences"* (PB, L1314-1316). However, it also worked towards protecting the PB whilst going through her own grieving process.

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Similarly, PA identified the potential for client grief to upset her emotional self. *"…when someone's in absolute grief, or has experienced massive loss, and you really are present in the situation, you are feeling it with them really, empathising and you know, erm, emotionally looking after yourself, I am very mindful of, because I can see potential for it upsetting my emotional self"* (PA, L444-449). In this example PA highlights the difficulty she has in managing the boundaries that protect herself from feeling the client's grief too intently. PA highlights that she can be so 'present' in the moment that she is mindful of 'upsetting my emotional self'. Therefore, to protect herself PA uses boundaries to separate her home life from anything that may be brought up clients in sessions. *"And bringing my issues then into the home, you know, family, friends, erm and I can't afford to let that happen, so I am on full alert for boundaries based on the emotions to keep my sanity"* (PA, L450-452). In this example PA is describing the potential impact of her feelings from client sessions impacting on her home life, and her need to keep them separate. The seriousness of this is emphasised with the use of language 'full alert for boundaries' which suggests a defensive position from PA. The language used also suggests (similar to PE), that PA perceives this as some form of attack against the self. To protect herself PA establishes self by identifying that her clients grief is not her own. This separation of client and counsellor is an important realisation for PA regarding boundaries. *"And I suddenly realised other people's grief was not mine, and I was not allowed to own it, it I was actually robbing them of their chance to grieve properly, and it really helped"* (PA, L479-481). By establishing self PA is able to see a future in her career with a reduced likelihood of burnout because she could not only separate herself and her client; but was also aware of the negative impact on her clients when she was unable to make this distinction.

PF appears to have already had a distinction between herself and the client. However, her difficulty came in having permission to acknowledge it. A pivotal experience before she was even a counsellor enabled her to distinguish the importance of role boundaries, whilst also acknowledging the distinction between what she did and what the client wanted.

"So, it was that, you know what I mean, no matter how good my intentions were, in terms of wanting to be there for people, in terms of my own self-care and in looking after myself, I needed to have really firm boundaries that people didn't step over. You know what I mean? And I think that ever since then, they've become firm and you know, put in place in that kind of way"

(PF, L340-345)

This experience enabled PF to firm her boundaries establishing her role whilst also confirming who she was. It was this experience that influenced how she was able to protect herself by giving too much of herself to clients.

PG also describes how she uses boundaries to separate herself from her clients. *"I`m aware I kind of have to ring fence something"* (PG, L277-278). This is a form of self-protection as PG acknowledges her vulnerability towards particularly 'needy' clients or hopeless situations.

"I also know, personal boundaries for my self is that, and this is something I have had to come and know and respect of my self is around self-care. And it might seem odd for someone who works in counselling, that I struggle when someone becomes very needy of me. And when that neediness kind of spills over to kind of consume the relationship, and I`ve had friendships were that's happened"

(PG, L249-254)

So, for PG acknowledging that what she experiences in sessions from a client is not part of her is important for her managing her self-care. For example, PG gives the example of holding onto deeply distressed feelings from a client from one week to the next, to find that the client had moved on by the next week, whereas PG was still in

that emotional place. *"I was kind of still stuck back here somewhere, and I'd come into the room with them and find they are somewhere else"* (PG, L298-300).

Similar to PE, PG is aware of the possible merging of client and counsellor.

"I am mindful in how I can feel in relationships like that, and I don't, and I certainly, it sounds odd for somebody in counselling because when I go into that relationship I am often myself to them, but I am often myself to them in a time, and I`m prepared for that, open for that, and that kind of doesn't bleed into other aspects of my life, so I have to be careful of that"

(PG, L265-270)

In this example PG not only appears to separate herself from the client, but also separates herself from herself. PG describes how she is often 'myself' but 'in a time' inferring that when she is with clients she is offering part of herself which may be different to the self she is at other times. This is to protect from the merge or as PG puts it stemming a 'bleed into other aspects of my life'. Interestingly here the use of the word 'bleed' is similar towards PE's use of the word 'contagious' it suggests a slow, creeping interference which needs stopping.

Finally, PA highlights the conflict between protecting herself and keeping herself separate from the client and the need to be authentic with her clients.

"Well I think with your friendships, your personal friendships you don't necessarily think about boundaries as much do you? You let your guard down as a person and let your personality out if you like, erm, if I needed to be guarded in a situation for whatever reason to protect myself that can sometimes be a barrier in the sense that the other person won't see the real me or I won't talk the way I would to a friend for example"

(PA, L723-728)

Again, the terminology of 'guarded' suggests a very defensive position towards her clients. PA discusses this in terms of her friendships versus counselling relationships. PA infers that being 'guarded' is appropriate in counselling relationships compared to her friendships. Although guarded infers that PA's focus is about protecting herself,

she suggests that it may result in an unhealthy block between client and counsellor. The separateness between client/counsellor that PA believes is important for the counsellor's safety has then become problematic for the therapeutic relationship. So, PA highlights the difficulty between balancing her authenticity and the protection of her emotional self.

Participants describe an attack on self through the merging and fusion of themselves and their clients. Either through shared feelings, lives or moments. The reaction from participants is often a firming up of boundaries. Particularly, boundaries of the self. That is the participant firming up a sense of who they are in a certain place and time. This establishes self – i.e. distinguishing their feelings and lives as separate to those of the client. This acts as a form of protection of the self.

Establishing Self: Comfortableness of Counsellor

Comfortableness of the Counsellor is a key theme within the transcripts (PA, PC, PE, PF, and PG). Participants consistently referred to their levels of comfort and discomfort when referring to boundary issues. Feeling comfortable was an important aspect of participants experience. Comfort in this respect appears to be a sense of safety and security. It was often related to participants who had established either their professional or personal identity. *"I`ve come to quite a comfortable position with myself"* (PA, L49-50). *"But I feel comfortable with doing that"* (PC, L193).

Participants inferred that a level of comfort was important in their management of boundaries. *"I was kind of, more comfortable thinking that the people weren't paying"* (PF, L203-204). How comfortable participants felt about either their own or their clients behaviour within the therapy sessions was a key component in making decisions

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regarding boundary issues. *"I didn't doubt myself because I'd already checked it out with my supervisor and I'd already, and the client and I felt comfortable with it"* (PE, L350-351).

Participants' level of comfort was often linked to their understanding and experience of shame. Using boundaries to avoid shame and fear meant that participants were more likely to feel comfortable in their practice. Discomfort can often be experienced as shame in any encounter (Kearns, 2006) and this appeared true for these participants also.

Participants used the security and safety of boundaries to create a sense of comfort. *"…so the boundary of actually releasing yourself from a boundary"* (PA, L782). PA describes a fundamental security in her sessions. That is, an established routine and structure to her therapy sessions that comforts her and make her feel safe so she can then focus on the client. *"…from those sessions that you start to relax…"* (PA, L793). This was echoed throughout the other participants experiences as comfort often related to a sense of safety for participants.

Interestingly, PB also identifies this sense of security as important, but also highlights what can happen when it is disrupted. In this example PB describes her discomfort when a client sits in the chair that she normally uses. *"…the first thing I said to my supervisor was "he sat in my chair" and she said "what did you do?" "I said I felt really uncomfortable I didn't know what to do with myself" and I knew that straight away!"* (PB, L1043-4). PB is able to identify that logically she should not react in this way, because after all she will just be using a different chair for that particular session. However, PB's sense of comfort is threatened when the routine of her sessions is challenged. PB reacts in surprise and shock towards this scenario. It also suggests

that the client may have crossed a personal boundary of PB's by changing the previously established routine of the sessions.

This raises the question of what happens when the counsellor is uncomfortable in the sessions. This ties in to the previous themes of fear and shame. As previously discussed the avoidance of fear and shame motivated participants as they aimed to be comfortable when carrying out their therapeutic work.

There is clear evidence from the other interviews that feeling comfortable is important when managing participants' boundaries within a therapy session. This is most evident when participants have been made to feel uncomfortable within their sessions. Usually this is a response to a client's behaviour which in some way challenges the personal boundaries that the counsellor has set themselves. However, it can also be about the counsellors own values and beliefs with regard to the management of boundaries in sessions.

Subtheme: Protection of Other

The second emergent subtheme was that of *Protection of Other.* Participants were able to identify boundaries as important to protect themselves but also to protect other people. *"…so it is about protection of yourself and protection of the other person"* (PA, L35-36). Protection of clients was usually the 'other' although sometimes the participants identified other groups to protect such as safeguarding children. Participants also identified using boundaries to protect the profession. However, overall the 'other' was usually their clients.

There were numerous ways that participants used boundaries to protect their clients. However, these can be broadly grouped into five further themes. These are: *Avoiding*

Exploitation and Abuse; *Ethics, Rules and Guidelines*; *Power Imbalance*; *Professionalism*; and *Safe Space*.

Protection of Other: Avoiding Exploitation and Abuse

Participants (PA, PD, PF, and PG) identified the risk of abuse or exploitation of clients as a central part of their understanding of boundaries. The boundary concept is used as a way of identifying the limits of a professional role, and to mark out the limits of appropriate or inappropriate behaviour of practitioners (Bond, 2015). Therefore, participants understood boundaries as a central aspect of protecting clients. *"I think if you were in counselling and you didn't follow any of those rules … you would quickly be in trouble … with issues yourself or...inflicting harm on others"* (PA, L329).

In addition to adhering to the appropriate boundaries PD identified the need for counsellors to act with the right motivation and purpose, saying *"everything that you do should be done with goodwill and not for personal gain or any kind of exploitative behaviour or conduct"* (PD, L8-10). However, Participant G still felt the need for a 'guard' against herself. *"And, I, you know, I wouldn't want to abuse any counselling relationship, and so I think the boundary sits there for me to kind of guard against, one way of guarding against the possibility of that happening."* (PG, L107-9). Whereas PF identified that the avoidance of abuse and exploitation by the counsellor was an understanding of the limits of their role, in particular understanding when the counselling relationship has ended and offering nothing more. *"There are boundaries like, not having a friendship, not having a sexual relationship with your clients, not exploiting your clients, you know what I mean, not exploiting your clients, [pause]. You know when the relationship ends, that the relationship ends"* (PF, L112-115). The use of boundaries to protect the client from dual relationships was mentioned by two

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participants (PD and PF). *"…are what I would call boundaries in terms of the limits of the relationship [pause] you know that when the relationship ends we can't now start up a friendship or start a business together or whatever it is, you know what I mean"* (PF, L116-119).

<u>Protection of Other: Ethics, Rules, and Guidelines</u>

Participants (PA, PB, PD, PE, and PF) understood boundaries to be related to ethics, rules or guidelines which offered protection to the client. PC and PG inferred they were related to rules but did not express this specifically. This supported the boundary literature which argues that boundaries can be understood in terms of ethics (Owen, 1997; Zur, 2004) or professional limits (Gutheil and Gabbard, 1993); marking out the edge of appropriate behaviour for professionals (Gutheil and Gabbard, 2003). *"We all work to a set of ethical guidelines"* (PD, L26). The majority of rules and guidelines that participants referred to were either professional standards or agency requirements. *"Now the doctor's office their rule was that if you see somebody out then you ignore them"* (PB, L1177-8).

Interestingly, 'ethics' was mentioned by very few participants but this aspect of the interviews appears to be linked with professional standards rather than as a standalone theme. Furthermore, there are only two participants (PD, and PF) who specifically mention the BACP or any other professional body in relation to ethical frameworks and guidelines with their references also being very limited. This suggests that participants do not have a strong association between boundaries and governing bodies. Participants were interviewed before the release of the new BACP ethical code which puts a greater focus on professional boundaries (BACP, 2016a). However, the limited references to it are still surprising.

Some participants identified their own personal rules and guidelines which they adhered to and influenced their understanding of acceptable behaviour in therapy. *"…sometimes swearing that might be something we set at the beginning, that we don't actually swear here"* (PA, L660-1). Whereas others identified the naivety of the public about what the rules of counselling are. *"in my experience, oddly I think, with all the stuff that's out there in the world people don't realise what we do and what we can't do and what the rules are"* (PB, L356-358).

Protection of Other: Power Imbalance

"I think it [boundary] always prompts me to remember that they're in a vulnerable position that you are as a counsellor in a stronger position in some ways" (PA, L29-30)

Participants (PA, PB, PC, PD, PE, PF and PG) acknowledged the power imbalance that exists between clients and counsellors (Proctor, 2002). PF acknowledged this in any kind of 'power relationships' (PF, L127). With counselling there is always a risk of *"…exploiting your power"* (PD, L21) as a counsellor and so participants felt that boundaries were there to stop them exploiting their power over clients. This acknowledgement of the power imbalance in the counselling relationship and the protection of clients with boundaries is covered in earlier sections. However, the participants' discussion of boundaries and power was much more complex than just acknowledging this imbalance.

Boundaries were deemed to be an important aspect of that power imbalance even when participants attempted to equalise that relationship.

"…but of course the client is going to still see, the boundaries of, you know, that you have more power than I have, within that relationship so, I think that there are kind of all those things of learning that no matter how you seek to equalise the, no matter how you seek to the whatever, that there are lots of issues that are there that are, that the other person will actually see"

(PF, L139-144)

In this quote PF expresses how she has attempted to equalise the therapeutic relationship with her clients but feels she has been unable to ever manage this fully due to the boundaries that are in place. For PF the role of counsellor may always been seen as more powerful by the client and she has accepted this as part of her practice.

Other participants acknowledged the need for boundaries to protect the client from the counsellors own personal issues. *"…and she didn't know what to do, there were very powerful parallels with parts of my life … and of course that meant a parallel process going on, I didn't want that to influence how I helped her"* (PB, L1280-5). For PB she used boundaries to keep her own personal life hidden from the client so it would not impact upon the session unfairly. It was only once the counselling sessions were over that she chose to share her own personal experience with the client. For PB boundaries could be used as a restraint towards herself.

Participants also identified boundaries as an important aspect of keeping control of the session (PA, PB, PC, PE, PF and PG). PC identified that clients may attempt to control the session themselves. *"Quite often, understandably, somebody else who needs to control is going to try and use that as a means to control their relationship with you. A power thing. It is quite important to be aware of that"* (PC, L244-7). PC also refers to being guard against collusion with the client when in sessions. For PC boundaries are an integral part of keeping hold of her power in therapy sessions.

PA stated that she did not feel powerless in sessions as she always felt she had the ability through her use of boundaries to keep control of the session. *"I never feel that I haven't got the power to control it"* (PA, L631). PA identifies that this may because she feels uncomfortable or fearful of what is going on in the session. However, she may also use boundaries to control the session if she feels that there has become a block in the therapy. *"I do feel I have the power to say, I`m really sorry I can't carry on now, you are really shouting at me too loudly, and we are not getting anywhere, we'll take a break, and then the next step would be we are going to finish now"* (PA, L626-9). For PA boundaries are a powerful to tool for managing sessions.

PE argued that she uses boundaries to 'set the scene' in her sessions but that the clients were still able to remain in control of their own boundaries. *"…but the client has got control of their boundaries because they can share something or not share something as the case may be"* (PE, L148-50). However, this emphasis on client control was delivered by the counsellor assuring the client that it was there and that they were allowed to assert their boundaries. *"…she's got control of her boundaries and I really emphasise that every session it's entirely up to you to share what you feel comfortable"* (PE, L155-7). PE did not appear to fully acknowledge her position of power in relation to the client. Although admittedly she did appear to try and equalise it in her practice through offering clients control over some of the sessional boundaries.

PB highlighted the difference between working with adults and children with her experience being that many of the boundaries that she put in place were implied with adults but had to made more explicit with children. *"I think, because you are working with children, and children live day to day, moment to moment, you've got to maintain it, constantly with them, you've got to maybe go over it, not repetitively but remind them, whereas adults, adults, it kind of in some ways explicit with adults"* (PB, L162-

6). For PB there was a greater amount of power in her role as a counsellor with children quite often because they were often more vulnerable because they were children but also because they may have been through some form of abuse. *"You can't assume anything, yeah, because you don't know what they live with you don't know what they are used to being acceptable"* (PB, L173-4). Therefore PB was able to acknowledge that her boundaries differed depending on the location of her power in relation to the client. This was in contrast to PC who felt boundaries were always the same.

Participants have numerous examples of 'breaking' or 'bending' boundaries as a way of furthering therapeutic outcomes or building trust with the client. For example, PB was also able to give examples of when she was able to 'give up' some of the power she had as a counsellor and allowed the client to take control of the session. Including things like taking cigarette breaks or using alternative venues for sessions (outside for example). PG gave an example of taking a client for an ice-cream and PE gave an example of going to an event with a client.

<u>Protection of Other: Professionalism</u>

"…you can deal with them professionally in work and have a separate life"

(PA, L536-7)

Participants (PA, PB, PC, PD, PF and PG) identified 'professionalism' as an important aspect of acting appropriately within their counselling sessions, and therefore upholding boundaries and protecting clients. Participants were able to distinguish between the counselling relationship and other types of relationship via the level of professionalism that they upheld.

"…it is a hugely intimate relationship but there is a boundary there, it is a professional relationship" (PD, L207-8)

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"And I think it is therefore very very important to maintain the boundaries that you know, this is not a friendship, this is actually a professional relationship that you are finding engaging with this person" (PF, L94-5)

Furthermore, professionalism appeared to be considered by participants as an aspect of the boundary concept that ensured a better quality of service for their clients.

"And I wanted to listen to them better, you know I wanted to develop the skills to listen to them in a lot, much more professionally than I think I was able to from just not following my innate listening skills, if that makes sense"

(PF, L226-9)

"You are working as a professional, you have studied for years to do all this, you are not giving them a service"

(PB, L333-5)

Participants identified professional behaviour as an important element in maintaining boundaries with clients. PC did not feel that she had had any difficulty with boundaries because she felt that she had always maintained what she considered her own professional behaviour.

"I can't really think of anything where there has been a real issue with boundaries. I am quite ... I suppose I try and maintain a professionalism. I tell them how counselling works and I think if you are clear about that then there is more of an understanding of how they would respond to that in a healthy way. I think boundaries can also be about ... really to maintain professional boundaries I think the therapy has to be quite healthy as well otherwise there might be an impact on boundaries because you are getting too close to the client. I think that could happen"

For PC professionalism was a key aspect of her understanding of boundaries and of her practice. PC upheld that being 'professional' was a key aspect of her practice although she was not always clear what this meant in practice.

In contrast, PG did not mention professionalism in her interview, except to refer to the reason why she did not complete counselling in a private practice.

"I don't, this isn't probably a boundary, I just don't, just a professional thing that I just haven't got the time to do that"

Despite the assertion that this decision is a 'professional thing', PG went on to describe a very *personal* reason for not counselling at home. Interestingly PE did not relate boundaries and professionalism and took a very context driven approach to her use of boundaries which focused on the client's needs rather than any idea of what might be considered 'professional'.

Protection of Other: Safe Space

"I guess in a way your boundaries have got to be really secure they have to be really trusted that this is a safe place" (PE, L195-6)

Using boundaries to create a safe space for clients was an important aspect of boundaries for participants (PA, PB, PC, PD, PE, PF and PG). *"Because boundaries I think is about enabling them to feel safe as well"* (PG, L103-4). *"…and the clients personal safety"* (PB, L10). *"…it is a measured approach to conversation designed to keep everybody safe"* (PD, L48-9).

As discussed earlier the participants often focused on keeping themselves safe. However, some participants identified this as an important pre-cursor for keeping the client safe. *"…because of the counsellor is not safe then the client will not have a good service"* (PB, L15-6).

PE acknowledges that there may be struggles between the client and the counsellor but that is all part of managing the relationship boundaries. PE uses the example of clients who have been through abuse. *"…what's needed is a very consistent relationship and that's part of holding the boundaries, not to take it personally, if there's these pulls and pushes but to actually keep a safe place"* (PE, L79-81). For participants it was about creating a safe space that could 'hold' the client and the therapy through all of the different challenges. *"It's holding that boundary that is really safe"* (PF, L501). PB gave the example of couples counselling which she suggested needed particular intervention and boundaries to ensure the therapy was safe. *"I don't think that's an agenda I think it's creating a safer space"* (PB, L250-1).

The safe space that was created in the counselling sessions was differentiated from other aspects of the participants' lives.

"…yet in the counselling situation you're trying to create that space, to feel and the even more intimate sometimes than your own friends, 'cause you don't always go on that level with friendships do you? But you are creating that sort of environment so that the person can work therapeutically through their issues"

(PA, L729-733)

In this example PA identifies how the safe space is about creating something that is so secure that it can become *more* intimate than say a friendship because it enables such a high degree of trust and openness. This ensures that the client is protected

and enables both the client and the counsellor to explore the feelings and experiences of the client.

Theme Two: The Structure of Therapy

Participants (PA, PB, PC, PD, PE, PF and PG) concur with the view that boundaries serve to create a sense of structure in their counselling practice (Kent, 2013). This can be split into two subthemes which are *Boundaries as the Framework* and *Boundaries as Tools*.

Subtheme: Boundaries as the Framework

Participants (PA, PB, PC, PD, PE, PF and PG) were able to acknowledge that boundaries acted as the structural framework which held the therapy together. *"It is like a framework"* (PC, L411). This was acknowledged by some participants directly whereas others inferred it.

Boundaries as the Framework: Outer Limits versus Inner Boundaries

For participants boundaries demarcated between the counselling session and the outside world and indicated this through their understanding of boundaries. They were often referred to as rules, lines or limits of behaviour. *"…that's kind of knowing that relationship exists within a very firm boundary in the therapeutic context"* (PG, L31-2). Participants identified boundaries as containing the therapy process.

"I don't work privately from home I am very clear about that for example as a boundary. Although, you know, we kind of speak about the length of sessions that we would have

and so on, the client ultimately decides that, that's not for me to decide. But we kind of, for me it's about containing it within, within those sessions rather than, because it would be very easy for me here at college to be available to somebody at college at any point in time. And so, you know, I'm kind of quite fixed about that."

(PG, L34-40)

For PG boundaries are there to contain the therapy process. The client is enabled to have freedom and choice within that process but must at least be part of it. This ensures consistency for clients. *"Because this is a relationship that I`m offering that is bounded"* (PF, L504). However, this also enabled a sense of consistency for counsellors too. *"Boundaries are what keep us on the straight and narrow and keep us able to justify everything that we do in our client work"* (PD, L11-2).

The majority of participants identified that there were a set of external boundaries that existed so that the therapy could be facilitated. Interestingly PC who was trained in the psychodynamic tradition advocated that the boundaries were always the same in her sessions. For PC her psychodynamic practice was clear about boundaries, it was about professionalism and adhering to the rules. This meant a clear structure from which to practice. However, other participants were able to identify strict external boundaries as important for structuring the therapy but that the sessions themselves could have very varied boundaries which were context specific. Each counselling relationship was therefore *"…unique with a generic set of rules"* (PA, L322).

Participants identified the boundary concept as a marker for indicating what is and is not appropriate behaviour within their therapy sessions. They described it as a 'line' or a 'fence' that identified the outer limits of therapy. The counsellor can use them to *"set the scene"* (PE, L148). So, boundaries were helpful for *"knowing whether you*

were overstepping the mark or not" (PD, L72*)*. PB said it is *"literally it is a line you don't cross over, erm, its, again a line you don't cross over, parameters you work within"* (PB, L8-9).

However, other participants identified that crossing boundaries was a very personal choice, saying *"my boundary is my line that I will not cross, or will cross but it will be a mindful consideration as to whether I shall cross it or not"* (PA, L275-7). PD concurred viewing some boundaries as fixed, and others as flexible, *"[b]ut you can't get away from what we discussed right at the beginning that there are some you can't cross, there are some that will be there forever but some have to be viewed as flexible"* (PD, L368-9). In contrast, PE initially identified the idea of a 'fence' with the boundary concept but quickly identified that this conceptualisation did not fit in to her idea of what counselling entails.

"Yes do it another because I am going to struggle for that, because what I am thinking of is a fence that's how I'm thinking of it and but that doesn't necessarily, that's not quite so easy to fit in with counselling [laughs]"

(PE, L33-5)

PF identified the need for the marker to be visible for some clients, to support in the therapy process. *"They say a child needs to know that a boundary or a fence is in place so that they can kick at it a bit. To see whether the boundaries stay up or the boundary actually falls down" (*PF, L453-6*)*. However, PA highlighted the difficulty of trying to maintain a boundary without it becoming something which stops rather than facilitates therapy.

"that probably sums up the word boundary doesn't it? It is a definite fence around you really... but it is the art of being able to keep that boundary in place without it being a barrier"

Whereas PB struggled with many of the boundaries placed on her from other sources such as social or legal influences.

"Weirdly, a lot of laws, erm, within our social system create situations like this, don't hold a child's hand, you know, you want to give a hug at the end of a session, don't do that, (coughs), so a lot of counselling is influenced by legal social barriers"

(PB, L797-800)

Participants differed in their understanding of what that external framework was for. For example PB saw it for the protection of herself whereas for PC it was about maintaining professionalism in her practice.

Boundaries as the Framework: Aspects of the Framework

There were other elements of the participants' experience of boundaries that could be considered part of the framework of therapy. These often occurred as tensions within the participants practice. Similar to the previous theme where boundaries were both the outer structure of the therapy process whilst also influencing the internal workings of the therapy relationship. There were three other *Aspects of the Framework*. These were: *Explicit versus Implicit Boundaries*; *Flexible versus Rigid Boundaries* and *Practical versus Theoretical Boundaries*.

Participants identified that they used both explicit and implicit boundaries within their practice (PA, PB, PC, PD, PE, PF and PG). Explicit boundaries were often used to outline the therapy process for clients, ensure that they were clear about boundaries or to re-inforce a rule or expectation. Participants would often be happy to outline rules or expectations with clients which were standard areas of practice such as time limitations of therapy for example. *"…working within whatever time boundaries that you have"* (PF, L99-100). PB highlights how many clients do not know what

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counselling is about and the expectations of them. *"People have no awareness really of what it is really all about"* (PB, L362-3). However, participants were much more likely to rely on clients understanding boundaries implicitly if it was a topic which the counsellor considered uncomfortable or difficult to talk about. These examples have already been given in previous sections such as charging clients or discussing the erotic in therapy. Some participants highlighted how boundaries were not part of the terminology of their practice. *"I never use the word boundaries or have to be so explicit about it. I don't think I have ever had a need to"* (PC, L61-2).

Another aspect which was highlighted by participants was the use of *Flexible versus Rigid Boundaries.* Some participants (PB, PD, PE, and PG) were able to identify areas where they had both rigid boundaries and flexibility boundaries in their practice. These participants did not appear to struggle with the ambiguity of different boundary decisions and could quite happily switch between the use of rigid and flexible boundaries. PD says:

"That is the way it is. That is the way life is. Something that can be rigid and apply one month and then down the line, things change and it isn't. But you can't get away from what we discussed right at the beginning that there are some you can't cross, there are some that will be there forever but some have to be viewed as flexible"

(PD, L365-8)

For PD his use of boundaries had changed over the course of his practice and he felt more confident in using a variety of boundaries. PD was also able to identify boundaries he felt comfortable in blurring by using new or different techniques as long as it helped the client or worked towards therapeutic efficacy. Similarly, PB struggled to define boundaries because she saw their nature as something that was ambiguous and changing dependent on the client that she was working with. PB says:

"…also I would say with boundaries it is difficult to define them as a perfect thing because they get fuzzy in some areas of counselling, depending on what kind of client you are working with, but there are set things that I believe should always be in place"

(PB, L10-4)

Despite not seeing boundaries as a 'perfect thing' PB does not appear to have any difficulty with this ambiguity as she reacts (possibly intuitively) towards boundary issues in her practice. PE was also comfortable with this paradox. PE gives an example of clients who are also substance users and the impact of this on counselling sessions. For PE the boundaries between her and the client can be breached. Interestingly, PE does not appear to enforce rigid boundaries in response to this type of behaviour compared to PD who does (by stopping sessions or rearranging). PE takes it upon herself to reassert her own self (i.e. check that she can tell which feelings in therapy are hers or the clients) which strengthens the boundaries between the counsellor and the client. However, it still ensures that PE can take part in the session. In this example PE is again protecting herself whilst also enabling the session to continue.

In contrast, other participants identified clear and rigid boundaries as an important aspect of their practice (PA, and PC). For both these participants boundaries appeared to be important for holding together the therapy but also to reassure the counsellor that they were safe and secure within each session.

The type of therapeutic tradition that participants came from did not appear to always influence their approach to boundaries. Certainly, PC psychodynamic training influenced her approach to boundaries as she appeared to approach it from what appeared to be the therapeutic frame. Other participants' person-centred training also influenced some of their boundary decisions (PE, PF, and PG). However, participants' use of rigid or flexible boundaries appeared to be idiosyncratic and context based.

"Well they are fundamental and vitally important but of course we are all individuals so they will mean different things to different people and the flexibility of boundaries will be different for different people too. Some people will be very, very rigid whereas other people will be a little more pragmatic perhaps but there are boundaries over which we could never step"

(PD, L15-20)

Some participants (PA, PD, PF, and PG) also identified a difference between *Practical versus Theoretical Boundaries*. For PA there was a variety of theories which she identified as helping her with boundaries. *"…some of those theories have helped me enormously"* (PA, L217). This meant that she was able to adapt her practice from completely person centred. PA was the only person to mention that theory had helped her with boundaries in her practice. PE identified how she had moved from theory to practice. *"…it's definitely developed because it can move from sort of theory, into how does it actually pan out with different people. So it definitely does change"* (PE, L270-2). Whereas PF who taught on person-centred courses did not link the use of theory towards her use of boundaries. PA highlights a possible reason why participants may not associate theory with boundaries.

"…but I think the boundaries in that level are almost on an academic level, you have to think about how you're working and not be tempted into using techniques to draw the person into a certain direction"

(PA, L104-6)

For PA the 'academic level' is the ideology underneath the practice. That is the belief and reasons for approaching practice in a person-centred way. PA has already admitted that she has brought in other models to her practice and that has influenced her use of boundaries. Therefore, how can she fully maintain the person centred principles? Therefore, she distances herself from this through her argument that these boundaries are at the academic level – i.e. there in theory but not always in practice. This is not to see what PA does not hold person centred values but that she views her

practice as something else. This cannot be assumed for all participants. However, it does indicate a possible reason for participants not associating theory with their use of boundaries as it may appear to abstract a concept to their actual practice.

Subtheme: Tools of Therapy

The final subtheme found within the interviews was the *Tools of Therapy.* Participants (PA, PB, PC, PD, PE, PF, and PG) identified boundaries as important tools in the delivery of their counselling practice. Boundaries were used to complete a variety of tasks and these could be split into the following: *Building Trust; Control; Directing Flow; Managing Expectations; Teaching;* and *Therapeutic Outcomes.*

Building Trust

Participants (PC, PE) use boundaries as a tool to build trust with their clients. They did this through offering consistency and security through adhering to the boundaries set out in the contract and that had been agreed to between the client and counsellor. For PC and PE the reason clients came into counselling may have been because of *"…people not keeping to what they have said and a lack of trust"* (PC, L56) or *"if people have come from unpredictable relationships"* (PE, L219-20). Therefore, boundaries could be a way of gaining their trust and enabling a more open relationship in therapy. For PE this meant showing a consistent approach to the client. *"And if that's done consistently then yeah it creates trust and now trust has to be based on both sides"* (PE, L215-6). One area which was often highlighted was of confidentiality. *"I guess in*

a way your boundaries have got to be really secure they have to be really trusted that

this is a safe place that it is not going to talked [about]" (PE, L195-7).

Control

Participants (PA, PB. PC, PD, PE, PF and PG) used boundaries as a tool to control the session with their clients. This varied within the participants from what may be considered minor attempts at control such as the time limitations of sessions through to more major uses. PA described her use of boundaries as a very formal and direct way of keeping clients behaviour under control.

"…that has to be a formal contract of behaviour really, that is really useful if someone becomes very angry, because you can refer back to the rules that you set at the beginning on norms and behaviours, again pull that from all my training and I think that actually it is a nice useful tool really to start off any relationship with, and you can refer back and say, "I'm feeling uncomfortable this is not how we set it, I`m sorry I am not going to continue if you carry on really", it's a way out, of er a situation sometimes and I`ve been under threat several times, erm, over the years"

(PA, L351-9)

As previously discussed this approach from PA was related to her fear surrounding the client's behaviour. Boundaries were used here as a tool to outline the exact way that the parties may act in a formal contract ensuring that PA felt in control. Whether this contract could actual influence the client's behaviour or not is unclear but what it does do is enable PA to stop the session at any point when she feels she has lost control of it.

Similarly, PB uses contractual boundaries to ensure that there is an element of control within her couples counselling sessions.

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"I`m convinced when you work with couples you need to have quite firm boundaries about listening, about …about giving the other person the respect, because sometimes in the relationship again, you might have forgotten to respect each other, and scream at each other, or ignore each other, or one will talk and one will say nothing, so… again it's a good tool, to work, to work with"

(PB, L239-44)

For PB she is able to control the session and ensure that each half of the couple is listening to each other by implementing boundaries as a tool to facilitate the discussion. For PB without using boundaries in this way there is resulting chaos to each session which she says is unmanageable.

PC was aware the client attempting to control the session. "…somebody else who needs to control is going to try and use that as a means to control their relationship with you" (PC, L245-6). However, PC attempted to break down that boundary by bringing the issue out into the open. *"…if appropriate to bring that into discussion with the client as well. 'I just noticed you seem to be ...' and then talk about it a bit more"* (PC, L247-9).

One of the most interesting tools that a participant used for control was the joy/pain box. This example could also have been linked to the Establishing Self theme earlier as it identifies how PA keeps the clients issues separate from herself.

"…one is the joy and pain box which is an imaginary...erm imaginary box if you like in my head or whatever, that I can just close down issues, and erm keep away until I see the client again so it is like an imaginary/visionary way of dealing with an issue"

(PA, L470-473)

For PA this is a tool for separating herself form the client and protecting herself form their emotional distress. Furthermore, it is a way of keeping the sessional work separate from her private life. This works well with PA's distinct way of keeping the different aspects of her lives separate and distinguishing between her different roles.

This is similar in the way other participants distinguish between their own feelings and the clients (e.g. PB's feelings of grief). Although PA is much more explicit in the method of how she does this.

Directing Flow

Participants (PA, PB and PE) related boundaries to directing the flow of counselling sessions with clients. Participants identified the counsellor as responsible for directing the counselling flow. *"But as for directing the flow...the flow of the session I do think the responsibility ... yeah is on the counsellor ... that if things are going badly, and the boundaries are not being adhered to then the counsellor needs to take responsibility for that and close the session down really"* (PA, L604-7). This is also true for PB who identifies the counsellor's role in using boundaries to direct the flow in certain situations despite her person centred training. *"…it was interesting because, when you make a contract with couples some people, person centred that I am, some people will just say – 'oh just let it go', let it go with the flow, but I think if you don't have boundaries set, that you're not screaming at each other, that you, if one person talks you must listen"* (PB, L230-5).

In contrast, PE identified the 'flow' between people rather than the flow of the session. For PE it was important to her to maintain that flow between two people because any breach could disrupt the session. *"It is very intangible. Yeah completely. But there are all these, I mean you know there's like a flow, isn't there, in relationships that you can't see, and they will, they can be breached"* (PE, L461-3). PE uses tools to ensure that she can ensure that this boundary is not breached such as grounding herself before sessions.

In addition other participants gave examples of how they directed the flow of session with the use of boundaries. Many of these have been detailed earlier in this thesis for example PD closing down sessions to ensure the erotic was not discussed in therapy.

Managing Expectations

"Sometimes boundaries is about offering what you say you offer and not offering more than that" (PC, L57-8).

Participants (PA, PB, PC, PD, PE, PF, and PG) used boundaries as a tool to manage the client's expectations. *"I don't want them to become confused about what this relationship is. And I know that that can happen with such an intimate relationship"* (PG, L104-6). "…understanding so that the client knows what the expectation is" (PC, L19-20). For PA this also meant alleviating any worry that she may have had surrounding the session as she has laid out the expectations.

"Once I`ve got my contract in place and the boundaries set with the...with the client, I try and become a blank piece of canvas without my prejudgements and my life experience as well, and that's given me a lot of confidence and I worry less"

(PA, L770-3)

For PA being able to set out the expectations to the client enables her to then make a conscious choice to aside all of her own thoughts, feelings and experiences. It is as if that by knowing that the client knows 'the rules' that this means that PA does not need to worry about what may come up in the session as she has established what she will do in the session. Most of the participants also referred to laying out the rules of the session for clients as part of their use of boundaries. Whereas PA appeared to enjoy this level of formality, PB shared a sense of regret that this was how it was set up. "You know counselling can be quite formal in a way, and I think sometimes that's unfortunate, but that's how it is set up" (PB, L367-9). For PA and PB this offered a

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level of security for the counsellor (and client). However, PB inferred that the counselling relationship lost something by being so formal.

PE acknowledged the need for clients to test the boundaries of the relationship and it was important to ensure that they knew they were safe. *"…you need to know that if you push against something naturally [claps hands] it's going to hold"* (PE, L222-3).

Teaching

"…you give them a tool" (PB, 214)

Participants (PA, PB, PC and PE) were able to highlight how they used boundaries to teach their clients. *"…and you learn to teach, I don't know if teach is the right word, gain/give the client the tools to help themselves, learn the boundaries, you know"* (PB, L633-5).

PA used boundaries to try and teach some respect to her clients who were young adults.

"…but having that rule has commanded a certain... respect is maybe the wrong word because I hope I earn my respect the way I treat people, but not being able to swear with me, they're not...some of the clients are not used to that, and not used to having that expectation on themselves either, and it actually seems to create some self-respect, so I use it, you know, it's worked and I use that"

(PA, L692-7)

PA wavers in her use of the word 'respect' here but nevertheless she uses boundaries to stop her clients from swearing. This tool offers the clients an opportunity to reflect on how their behaviour is perceived by another and also how it may not be deemed acceptable in all settings. PA is asserting her own boundaries here (i.e. it is her own boundary rule rather than agency or tradition) although she argues that these are therapeutically based and not personally motivated choices.

PB uses her application of boundaries in her sessions to teach others the appropriate way to socially interact to both children and adults who have not experienced appropriate boundaries before or been victims of abuse.

"…because they have only ever seen inappropriate behaviour towards them, if you show them an appropriate way of being with a child they'll appreciate themselves better, so in that respect, boundaries with children really is a (inaudible) part of teaching them how it is to be socially, so, there are some children who have learnt to be inappropriate with adults, without them realising it is wrong"

(PB, L153-9)

Summary

The IPA analysis resulted in two main superordinate themes: Protection and Safety and the Structure of Therapy. This can be split down into four further themes. Protection and Safety can be broken down into: Protection of Self (i.e. the counsellors' propensity to protect themselves) and Protection of Other (i.e. the counsellors' attempt to protect others, particularly the client). The superordinate them of the Structure of Therapy can be split into Boundaries as the Framework and Boundaries as Tools. Although there was interest in all themes the issue of self-protection dominated the analysis of the interviews and is the theme which forms the backbone of this thesis.

The IPA analysis was not sufficient to evidence and represent the participants' understanding and experience of boundary for the reasons laid out in chapter three. However, there are key aspects of the IPA analysis which run as themes through this thesis and are central aspects of the two models presented in the next two chapters. The role of self-protection when using boundaries was a dominant theme in all the accounts and was a significant aspect of the participants' accounts. It is central to the models presented in the next two chapters which further explore these issues in these chapters such as the impact of shame and fear on counselling practice.

Chapter Five: The Process of Boundary Decision Making

The second aim of this thesis is: **to investigate counsellors' understanding and experience of the concept of 'boundary'.** The findings of this thesis answer this aim and are detailed in the following two chapters. The findings are represented as concisely and coherently as possible to ensure I keep within the space limitations of this thesis. Any additional discussions or elaborations that are needed are presented in the appendices section.

There are two models which have been created from the findings of this research. The first is a process map of how counsellors approach and respond to boundary issues in their practice. I will detail the terminology used within this model with a very brief overview of how I came to using these terms. I will use the terms to propose a process map of participants' responses to boundary issues. I will then explore this process in much more detail using participant accounts to highlight each aspect. This will highlight the following: that it was difficult to define 'boundary' in a singular definition because participants of this study had an idiosyncratic understanding of and approach to boundaries; counsellors often experienced shame and fear when confronted with boundary issues; how counsellors *responded* to boundary issues was often a more useful exploration than how they defined boundaries. I will then detail how this model was constructed including the discovery and influence of the Amoeba Principle and triangle of conflict. This thesis also identified that counsellors understanding of boundaries often differed from their experience of them. This will be discussed in more detail below.

The second model is a more detailed look at the different types of responses that counsellors use in relation to boundary issues. I have called this model the Boundary

Response Model (BRM) and it is detailed in *chapter six*. The BRM is a representation of how participants respond to boundary issues within their practice. In the rest of that chapter I will outline the BRM and the predominant characteristics of each element. I will then detail the impact of the *Compass of Shame* model as developed by Nathanson (1992) and the participants' accounts on the Boundary Response Model. I will use detailed examples from the participants' accounts to evidence why the model is useful in practice. Finally, I will highlight why the BRM represents a contribution to knowledge and how it can be used to facilitate a broader discussion of boundaries in counsellor training and supervision.

Boundary Process Terminology

This research has identified a complex relationship between various aspects of the boundary concept as understood and experienced by counsellors. Terminology, therefore, is extremely important. So, before I detail the full findings of this study I will give a brief overview of the terminology used within this chapter which is important for the Boundary Process Model. These terms and definitions have been produced by analysing the participants' accounts. I have highlighted these new terms in **bold** throughout this chapter for emphasis and whilst the reader becomes familiar with them. The working definition of 'boundary issue' which was detailed earlier in this thesis has been broadened even further here to include *all* influences on the therapeutic encounter. A summary of each term is given here to introduce them and support the process map which is detailed straight after them. This then leads onto a more detailed discussion of each term and supporting evidence later in the chapter.

Boundary Understanding

The counsellors' '**boundary understanding'** can be defined as how counsellors consciously define boundaries – that is their understanding of them.

Boundary Attitude

The counsellors' '**boundary attitude**' can be defined as how counsellors approach boundaries in their practice. This can be both their conscious and unconscious approach to boundaries. Participants' boundary attitude was mainly influenced by their own values and beliefs.

Boundary Issue

A '**boundary issue'** is defined as any aspect of counselling that impacts on the therapeutic encounter. This is slightly different from the previously identified working definition noted in *hcapter one*. It has been broadened to encompass *all* aspects of the therapeutic encounter as per the participants' accounts.

Boundary Experience

The counsellors' '**boundary experience'** can be defined as how a counsellor feels when faced with a boundary issue. Participants in this study often detailed feelings of shame and fear when faced with boundary issues which resulted in further uncomfortable and anxious feelings.

Boundary Response

The counsellors '**boundary response'** can be defined a counsellor's response to boundary issues in their practice. Participants of this study identified responding defensively to many boundary issues because of feelings of shame and fear. *Chapter rsix* details the Boundary Response Model (BRM) which represents how participants responded to boundary issues in their accounts and details eight distinct responses and related characteristics.

Boundary Feedback

'**Boundary feedback'** can be defined as the information that counsellors receive once they have responded to a boundary issue. For example, their own feelings, the perceived feelings of the client as well as any perceived therapeutic benefit to the client.

Context

Participants identified 'context' as an important element when responding to boundary issues within their practice. For example, PD states *"it all depends on the circumstances and of course the application of boundaries will always depend on circumstances, cause every client is different and unique and should be treated as such"* (PD, L31-4).

Boundary Process Model

Each element detailed above has been identified as an important part of the participants' process when responding to **boundary issues**. This has come from the participants' accounts. However, before I evidence this I will give an overview of this process for clarity before then detailing each aspect in more detail (with evidence from the accounts). This can be represented visually see figure 1 below. It is presented here first in a series of stages.

Every counsellor has a **boundary understanding** as they engage in a therapeutic encounter.

This process begins with the counsellor's **boundary attitude**; incorporating both conscious and unconscious elements of their approach to counselling; their idiosyncratic attitude to boundaries.

They are then presented with a **boundary issue** which can be *anything* that impacts on the therapeutic encounter which is not necessarily ethical in nature.

This results in the counsellor having a **boundary experience** which includes a set of thoughts and feelings over how to respond to this issue. These thoughts and feelings will bring both conscious and unconscious influences into how the counsellor will respond.

The counsellor then has a **boundary response** to the issue. This can be through a variety of ways which is detailed later in the BRM.

Once the counsellor responds then they will receive **boundary feedback** from the situation. This will include their ongoing thoughts and feelings about the issue, the client's response and any reflective thoughts about this response.

This feedback will then go on to inform the counsellor's **boundary attitude**, and so the cycle continues. All of this takes place within specific contextual boundaries of the session such as the time, place and organisational setting.
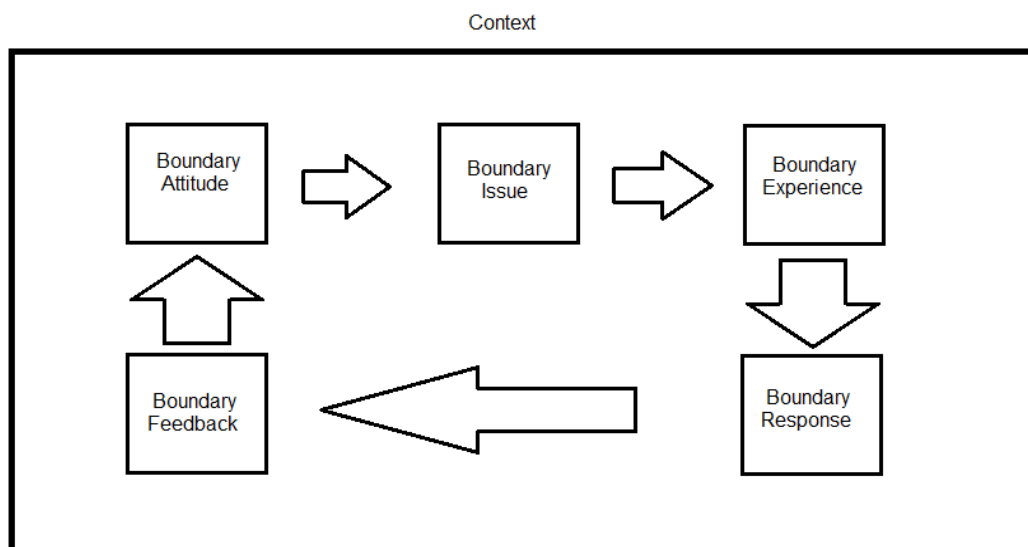

Figure 2: The Counsellors Process when Responding to Boundary Issues

The following section will consider the four cornerstone aspects of the counsellors' boundary issue process – Boundary Attitude; Boundary Experience; Boundary Response and Boundary Feedback.

<u>Boundary Understanding</u>

Participants were asked to describe and define boundaries – their responses were labelled their '**boundary understanding'**. When asked directly about what boundaries meant to them the participants' answers can be split into two broad themes – either the limitations of their role or the relational distance that exists between themselves and the client. However, despite being able to categorise their responses in this way participants placed their own distinct perspective on each of their answers. PA defined boundary as both the *"relationship boundary"* (PA, L16) and *"a separateness to the situation"* (PA, L20). PB described it as *"parameters you work within"* (PB, L9). For PC, it was *"a professional kind of distance between myself and my client"* (PC, L-8). For PD, it meant *"it means operating within a set of ethical constraints if you like"* (PD, L6-7). PE struggled to define the term at all but inferred that it was referring to the limits of the therapeutic relationship *"it actually is quite a boundaried relationship"* (PE, L60-1). Whereas PF described it as *"more to do with ethics and the boundaries that you maintain within the relationship"* (PF, L81-2). Finally, PG also struggled to put it into a single definition stating it was *"around the nature of our relationship as well"* (PG, L28-9). A consequence of participants' differing and varied understandings of boundaries is that any attempt to summarise their responses into one definition felt too reductionist because one singular definition would not have covered all of the participants' descriptions. Therefore, it is asserted that participants' understandings of the boundary concept is idiosyncratic and specific to the individual. This also supports

the argument that boundaries are too nebulous or amorphous to define in one single

definition (Gutheil and Gabbard, 1993).

Boundary Attitude

Through the use of pen portraits, it became apparent that each participant had their

own unique approach towards and use of boundaries which has been labelled their

'**boundary attitude'**. A brief overview of each participant's pen portrait can be seen

below. These are also a good representation of each participant's boundary attitude.

Participant	Summary of the participant's pen portrait.
PA	PA understood boundaries to be about the limits of the relationship between herself and her client. PA was keen to protect herself from her clients or from the client's life becoming part of her own and used boundaries to do this. PA had become more confident in implementing boundaries as she had developed as a counsellor over time this had made her more relaxed in her practice. Boundaries were an integral aspect of her identity and played an important role in both her personal and professional life.
PB	PB is fearful of being sued and so ensures she has the appropriate boundaries in place to protect herself from this. There is an indication that PB may be more relaxed with her boundaries if this threat did not exist. However, saying that PB is very flexible with her boundaries when it is for the benefit of the client. PB will be firm with some boundaries such as confidentiality.
PC	The dominant theme throughout PC's interview was that of *Professionalism*. For PC her experience of boundaries was that it was an aspect of her practice which evidenced her professionalism with her clients. PC states that she has never had a problem with boundaries in training or with clients. PC is confident in her use of boundaries.
PD	For PD the boundaries that surround the counselling relationship are rigid and inflexible. However, they are there to create a space which is compassionate and forgiving for clients. PD describes how boundaries are different for each person but that there are some that cannot ever be broken. PD is confident in his use of boundaries.
PE	PE discusses boundaries in terms of how they benefit the client. Power is often assumed to be with the client rather than herself. PE is happy to be flexible with her boundaries if it is for the benefit of the client. PE is confident in her use of boundaries.
PF	For PF having the permission to implement boundaries with others was an important aspect of her experience. This came from an experience before she had even trained as a counsellor but influenced her practice ever since. This experience was about getting permission to put in place her boundaries and was tied in tov her spiritual beliefs. PF is now confident in her use of boundaries but has been apprehensive in the past.

PG	PG is anxious around those who are needy or helpless and finds it difficult to implement boundaries if it means leaving someone in need. PG attempts to reinforce her boundaries through the places she works rather than implement them herself. PG acknowledges the dangers of loose boundaries for clients. PG was also anxious about her use of boundaries being judged by others. PG is apprehensive in her use of boundaries.

Participants' **boundary attitude** was a combination of: their understanding (i.e. their definition) of boundaries; their own values and beliefs; their training and their counselling experience. All participants expressed what they thought influenced their application and use of boundaries in counselling sessions. It was important to represent these influences in diagrammatical form. When considering this there were two aspects which stand out. The first, is the temporal nature by which boundary influences follow for counsellors. Boundary influences include the counsellors' own values and beliefs (often from their own personal experience and life before counselling); their counsellor training; and their experience as a counsellor. The temporal nature of these influences is evident because participants suggests that their attitude towards boundaries is deep rooted and often set before any training or experience as a counsellor has even happened. This supports the argument that a counsellor's approach to boundaries are often based on their personal and cultural experiences (Gabriel, 2005).

The second is the level of influence that each of these elements has - participants expressed a greater level of influence from their personal and previous life experience than from their training or experience as a counsellor. This is further evidence that training and counsellor experience were perhaps more minor influences in developing a counsellor's **boundary attitude**.

These findings are represented as a triangle in figure 2. The counsellor is at the top of the triangle, the width of the triangle representing the level of influence that each area has on the counsellor's **boundary attitude**.   The height of the triangle could also represent the passage of time. The points made here are discussed below with the use of quotes to evidence each point.
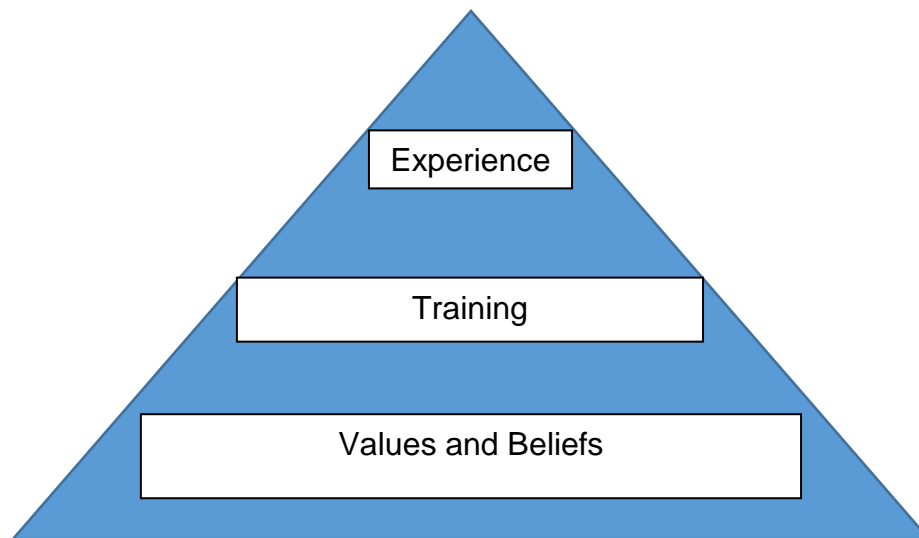
Figure 3: Counsellors' Boundary Attitude

Participants identified that their **boundary attitude** comes from their own inherent set of values and beliefs which are a result of their personal life experiences. For example, PD states that *"[t]hat is where it comes from. It doesn't get taught at college. There is an inherentness about it, if that is the right word"* (PD, L101). Participants often described their boundaries as coming from an inherent value base, something that appeared to be fixed rather than developing. In the above quote PD describes it as something which is in him, he says with '*an inherentness about it*' PD relates this to his early life experience and childhood, saying *"[w]e talked and we probably all wrote about our parental influences, our grandparents' influences, peers, teachers and siblings"* (PD, L97-9).

Similarly, PE recognises this influence on her understanding of boundaries. *"I think possibly some of it is something that perhaps we've all picked up as we go along from being small"* (PE, L235-236). This infers an almost developmental aspect to boundaries that we all somehow gain as we grow up through our interactions with others. PF is also able to identify that her boundaries are also caught up in her own beliefs and values. *"Yeah, but I think erm, it is an interesting question, where does my boundaries come from? My boundaries probably come a lot from my ethics and values, my own kind of ethics and values, and my belief system"* (PF, L258-261). To PF her **boundary understanding** is based around her own ethics, values and beliefs. Certainly, these qualities can be developed and changed over time. However, participants indicate that these qualities are somehow set separately from their development as a counsellor and come more from their development as a person. For example, PA states that *"Well probably your own beliefs, and judgements, which is why it is so difficult to define isn't it?"* (PA, L312-3). Similarly, PF identified her own motivations for training to be a counsellor as an influence on her understanding of boundaries. *"I do think that a lot of my ethics and values come from the reasons why I began the work in counselling in the first place"* (PF, L264-275).

For PB her own feelings and intuition is what guides her when making decisions about boundaries. PB states *"…'go with the guts' as they always say, yeah I think from the very early on when I did my counselling studies … so stop my head thinking and just be, and it was an element of just being, not thinking, just going with what felt, between you and that client, what felt right, although it wasn't a thought it was just a happen, you can't always pre-think things"* (PB, L87-93). In this quote PB identifies her own personal understanding of boundaries is instinctive –*'go with the guts'* (PB, L87*)*; and something that is felt rather than determined through logic –*'it wasn't a thought it was*

just a happen' (PB, L92-3). Her approach is reaffirmed by her tutor and thus used in her counselling practice.

This is similar to PD who identifies how counsellor training actually puts a label on the approach to boundaries but it is something that is already instinctively known beforehand. *"The training enables you to put labels on things that you are inherently are or inherently know to do"* (PD, L104-5).

PF has a similar experience when she received some training about boundaries when she was working as a group leader for an evangelical church. Initially PF was concerned that to put in boundaries would, in some way, be going against what she was trying to do achieve which was *"offering the love of God to people"* (PF, L272). However, training from the church leader resulted in her feeling as if she had permission to put in place firm boundaries with those she was working with – *"made me have to put boundaries [laughs] in; boundaries that I didn't have, at the time"* (PF, L277-8).

PF already instinctively knew her **boundary attitude** but needed permission before she would implement them with this client group. This is evidenced when PF is asked if the training worked as she states *"Yes, because, no, no no I can be very firm oh no I can be very firm with my boundaries"* (PF, 332-3). The *'no, no, no'* (PF, L332) is advising the researcher that 'there was no problem after this' and 'I was able to implement them fine' because she can be *'very firm'* (PF, L333) with her boundaries. This suggests that PF's **boundary attitude** comes from her own values and beliefs but is confirmed through her training. PF asserts her ability to be firm with her boundaries and infers that this would be a typical response for her. The atypical

response was her inability to affirm them because of her belief that by doing this she was not being able to offer the love of God unconditionally.

In contrast, PG highlights her own vulnerability regarding individuals who appear 'in need' or particularly vulnerable themselves. PG suggests that there is something within her that will always respond to requests from clients, and infers that she is often unable to uphold boundaries in such cases. *"Yeah, yeah, yeah. I know something about myself, if somebody was in need, I would never say 'no'. And I know that, and I know that if that was here, or I was working from home, I know that I couldn't do that, I couldn't…"* (PG, L627-8).

These examples highlight the powerful nature of the values and beliefs of participants in how they approach boundaries in their practice – their '**boundary attitude'**. They indicate how their personal values can have a direct influence on the work that they do. It also highlights how training (not necessarily counsellor training) and counsellor experience can influence the participants' attitude towards boundaries but to a much lesser extent than their own values and beliefs.

Boundary Experience

As discussed earlier participants approach **boundary issues** within their practice with their own **boundary attitude**; that is their general approach towards boundaries. However, participants also described how they *experience* specific **boundary issues** in their practice through a variety of emotional reactions to each of the issues, which was accompanied by the counsellors associated thoughts and reflections on the issue. I have labelled this the counsellors **'boundary experience'**. It can incorporate both conscious and unconscious thoughts and feelings. I will use examples from

participants' accounts below to evidence this and will then move on to considering some specific examples which are important for the BRM.

All participants detailed a variety of thoughts and emotional reactions when faced with specific **boundary issues**. Examples are given here.

PA identified how she *"could feel myself getting ground down really"* (PA, L491) when working in long term grief work with clients. PA said she questioned her own strength in dealing with this issue and *"thought I`m not sure how long I can sustain this"* (PA, L487). It was not until she finally acknowledged that *"…other people's grief was not mine, and I was not allowed to own it, it I was actually robbing them of their chance to grieve properly, and it really helped"* (PA, L479-81) that she was able to see a way forward. PA's **boundary experience** in relation to working long term with clients who were grieving was to feel their grief as if it was her own (PA's experience is described almost as depressive symptoms), to question the sustainability of this type of work, to acknowledge her role and the impact it was having on the client.

In another example, PE identifies how she is frightened when she experiences bodily changes when working with drug and alcohol clients. "…*when I first experienced it I was quite anxious, so I was thinking what on earth's the matter with me I felt fine before what's going on*" (PE, L466-8). PE's fear here surrounds losing control of herself and her body as the connection between her and the client is disrupted. PE reports that the client's drug and alcohol use has disrupted their connection and she has felt it in the therapy session. PE is uncertain why she feels the way she does and who the feeling is coming from (i.e. her or the client). Miller (2000) relates many of the therapist fears surrounding the loss of control in therapy as related to the body. For example, the client becoming too emotional, too angry or too noisy; not stopping the sessions

on time or the shame of the client not returning can all result in clients responding with their bodies.

There is also evidence of both conscious and unconscious feelings throughout the participant interviews. For example, PC was consciously aware of her fear of being sued or doing something incorrect in her practice. *"Petrified of being …that that's wrong this is wrong"* (PB, L805). Whereas PA was unaware of her fear of violence and it was only brought into her awareness through the research process. *"But what I didn't realise is, and even now talking to you, would be how much a part of that would be on my mind"* (PA, L416-417).

Research suggests that counsellors and therapists can respond with feelings of anger, anxiety, devastation, embarrassment, exhaustion, fear, impotence, panic, powerlessness, sadness, sense of failure and shame when faced with boundary issues (e.g. Moerman, 2012; Reeves and Mintz, 2001; Rodgers, 2011; Smith, 2003a).

These feelings can have a negative impact on therapy particularly if those feelings are unconscious. They may, for example mean that counsellors "…steer clients down more comfortable lines of thought and discussion in order to avoid additional discomfort in ourselves" (Adams, 2014, p71) because anxiety "…can undermine [their] sense of safety" (Adams, 2014, p64). These emotions may also impact at the organisational level. Wasdell (2011) states that "[i]ndividuals professionally involved in one-to-one relationships find themselves at the mercy of unconscious, irrational and often destructive forces being acted out at the corporate dynamic level of those organisations which bring psychotherapists, counsellors and analysts into organisational relationships" (Wadsell, 2011, p36).

For the interviews in the current study the participant **boundary experiences** then informed how they would respond to these **boundary issues** in future sessions. This also had the potential to influence the counsellor's use of boundaries in sessions. There were some particular emotional reactions to **boundary issues** that were more dominant than others and are important to discuss in more detail. These were feelings of shame and fear and are discussed in the next section.

Boundary Experience: Shame, and Fear

The **boundary experience** of participants was made up of many different emotional reactions and associated thoughts and it is impossible to look at every type of reaction within this thesis. However, there were two key emotions which dominated the counsellors' **boundary responses**. These were feelings of shame and fear.

Shame

Feelings of shame were a common experience of participants when faced with **boundary issues** in their practice. Throughout the participants' interviews shame was the emotion which dominated participants' **boundary experience**. Shame was only mentioned directly by one participant (PD). *"Yes, cause there is going to be a tinge of shame on it"* (PD, L122) but is evident in the other participant interviews when analysing their reaction to **boundary issues**. Evidence of this will be given in this section. However, first it is relevant to define what is meant by 'shame' in this context.

The literature on shame is broad (e.g. Blum, 2008; Gilbert, 2003; Gilbert, 2010; Gilbert & Andrews, 1999; Lewis, 1995; Lewis, 2003; Nathanson, 1992) and cannot be fully discussed in the limited space in this thesis. For this thesis, Nathanson's (1992) 'Compass of Shame' model will be used. This is a broad model of shame and the challenges of using such a broad definition of shame are discussed in *chapter seven*.

Nathanson (1992) argues that that there are nine basic affects that establish our very sense of self. These are interest-excitement; enjoyment-joy; surprise-startle; fear-terror; distress-anguish, anger-rage; dissmell; disgust; and shame-humiliation. However, Nathanson proposes that the shame-humiliation affect is the most dominant affect. He defines it as "a highly painful mechanism that operates to pull the organism away from whatever might interest it or make it content" (p138). Nathanson broad definition of shame includes experiences of shyness, guilt; embarrassment or humiliation. For Nathanson "whenever we realise that our face has turned abruptly from the previously interesting or enjoyable or empathic other, and/or our eyes become downcast, and/or our confusion bad enough that we are unable to talk, we are experiencing some variety of shame" (1992, p145). Nathanson's definition purposefully incorporates a broader array of experiences such as shyness which may not evoke intense feelings. However, it is this definition that was most useful in analysing the participants' accounts because it enabled such a broad array of experiences to be included in it.

Nathanson proposes that shame has an impact on our sense of self. Nathanson identifies that shame can on occasion appear to impact on the very 'core of the self' whereas on other occasions it appears to relate to very minor aspects of the self. Yet, "[i]n every one of these experiences of shame it is "I" who am embarrassed, yet in each I experience myself quite differently" (Nathanson, 1992, p189). Expressed within this quote Nathanson proposition is that we experience shame from two different perspectives: our own innate feelings of shame, and social shame learnt through our social interactions.

Participants' in the current study discussed experiences of shame which included both types. With their innate experiences of shame coming from their own values and

beliefs and their social shame resulting from their knowledge and experience as a counsellor. Both of these are discussed below with relevant examples. (It is important to note here that there are many multiple examples of shame experiences throughout the participants' accounts but only a few have been used in this section to highlight the main points. The rest of the examples have been used later in this chapter as supporting evidence of the BRM and are discussed in much more detail than the examples below).

<u>Personal Shame</u>

Participants' described experiencing two types of shame in response to **boundary issues** the first of which I have labelled as 'personal shame'. Personal shame can be defined as a counsellor's uncomfortable feelings that occur because of their concern that they will be judged unfavourably by either themselves or another because they have acted in a way that goes against their own values and beliefs. There are various examples of personal shame throughout the participants' accounts but I have detailed one example below.

PG describes how it would be particularly difficult for her if she worked in private practice and wonders if that is why she hasn't chosen this route for her career. *"…maybe that's why I choose to work here, because it doesn't kind of affect me that way. I think if I worked from home, in private practice, it would test me"* (PG, L639-641). Initially this quote may not seem to be related to the experience of shame. However, if we delve deeper into PG's experience we can see that it is related to shame. PG appears to have avoided private practice for fear of being able to uphold boundaries. *"…in private practice, it would test me"* (PG, L641). Initially, I felt that it was the client's need which motivated PG. However, further investigation suggests

that it is actually her own need which motivates her to break those boundaries. As she states earlier in her interview *"I couldn't be that person who didn't respond in their hour of need. I know that. Whatever time that was"* (PG, L636-637). PG suggests that being 'that person' who didn't respond to a client is not who she wants to be as a counsellor, as set by her own values and beliefs. Therefore, PG infers that she would experience some form of guilt by not responding to this request which under Nathanson's (1992) definition means she is experiencing shame. Another way of looking at this example is if PG does not respond then she will experience shame from the client for not answering their request. PG admits that she would respond whether there was a breaking of a boundary or not. This suggests PG does not want to be viewed as 'that person' by the client (or possibly others) and evidences a change of focus from the client to herself. This is her own personal shame because it is motivated by her own beliefs and values rather than being viewed as unprofessional by her peers.

Counsellor Shame

The second type of shame participants felt described experiencing in response to **boundary issues** I have labelled as 'professional shame' or 'counsellor shame'. Counsellor shame can be defined as a counsellor's uncomfortable feelings that occur because of their concern that they will be judged unfavourably by their peers or the profession because they have acted unprofessionally. There are various examples of counsellor shame throughout the participant accounts but I have detailed two below.

PD says *"if you do something in counselling that you wouldn't want to tell your original tutor, it is likely to be wrong"* (PD, L119-20). In this instance PD evidences 'counsellor shame' by arguing that anything he does which his original tutor would disagree with is '*likely to be wrong'* (PD, L120). PD is effectively using shame (or imagined shame)

to guide his behaviour with his clients. If an action is judged as incorrect by his tutor then it would surely be considered a shameful act as the counsellor had gone against their teachings. The *'wouldn't want to tell'* (PD, L119) aspect of this quote also indicates feelings of shame.

'Counsellor shame' often arose as a reaction to specific **boundary issues**. For example, PG withholds information about her boundary breaking with her employer on one particular issue (taking a client out for an ice-cream) but not another (breaking confidentiality). *"But college were aware of that. So that was kind of recorded and that was monitored, and we kind of made the appointment. But they didn't know about the ice-cream"* (PG, L208-11). Interestingly PG believes that both of these interventions were in the clients interest and justifiable in her practice. However, only one was disclosed or shared. This appears to be because the breaking of confidentiality is an acceptable form of boundary breaking because it was part of safeguarding the client. *"I broke confidentiality about her kind of potential harm to herself"* (PG, L196-7). In contrast taking a client out for an ice-cream is potentially less acceptable to peers and therefore could result in experiences of counsellor shame for PG in breaking this boundary. *"And I guess I would have had to face the consequences if anyone else became aware of that"* (PG, L178-9). The difference in disclosure appears to be related to avoiding the shame affect (i.e. appearing unprofessional) rather than being necessarily in the client's interest. Although PG does not appear to have done anything which endangers the client in any way and has reasons to justify her actions she appears to be fearful of others finding out about this broken rule.

It was not always possible to distinguish between 'personal shame' and 'counsellor shame' in the participants' accounts as sometimes it was not clear the reasons for the participants' feelings. For example, PC said *"I feel a bit [un]easy in asking them"* (PC,

257-8) in relation to asking a client to take off their shoes. The awkwardness and embarrassment is clear from this statement but it is uncertain if the counsellor felt embarrassed as a professional (for example because she had to ask a client to take of their shoes at another person's request) or personal (for example because the client was a male and she was female).

Shame: Incompetent Professional Self

Participants' experiences of counsellor shame were often a result of feeling that they had made a mistake, or some form of error in their practice. Nathanson proposes that shame, is an impediment to the expectation we have of our self; an unexpected interference to our enjoyment or interest in something. He says *"*[s]hame is so uncomfortable that it can cause a lingering sense of wariness, or willingness to trust positive affect quite so easily*"* (p210) and that he suspects "that shame produces a *sense of an incompetent self,* that there is a part of the *self* created by shame" [italics original authors] (Nathanson, 1992, p211).

Shame therefore, can be associated with feelings of incompetence defined as "moments where a therapist's belief in his or her ability, judgement and/or effectiveness is diminished, reduced, or challenged internally" (Theriault and Gazzola, 2005, p12). Some participants in the current study suggested a lack of confidence surrounding some **boundary issues**. This was often related to how they perceived their competence with that particular issue. Sometimes participants identified these feelings directly. *"…well I was... so green to it, and scared of going into the situation really"* (PA, L791-2).

However, often they were expressed much more covertly. PC describes the importance of not going over time boundaries. *"All the professionals just won't do it.*

The reason I think it is good, and it is a challenge for me, is that it just doesn't give that client that feeling of knowing where they are" (PC, L219-22). In this last quote PC expresses her view that '*professionals just won't do it*' (PC, L219) yet describes how she often struggles to 'do it' by saying '*it is a challenge for me*' (PC, L220). This then suggests that PC then sees herself as unprofessional in this context. This is likely to invoke feelings of shame particularly when we consider that PC's **boundary attitude** holds an importance to being professional. These **boundary experiences** can be labelled feelings of incompetence because they express the counsellors concerns about their own ability as a counsellor. They will also form part of the participants' experience of counsellor shame.

Arguably then, it is the shame affect that causes feelings of incompetence. Nathanson states that "[w]hile it is clear that shame affect is triggered by experiences that have nothing at all to do with competence, shame produces awareness of an incompetent self" (p211). Given that I have identified that counsellors have feelings of incompetence when responding to **boundary issues**; I would suggest that counsellors' experiences of shame in therapy will often be associated with how competent they feel. This, in turn, could influence their **boundary responses**. Kearns (2006) suggests that there is an increased sensitivity towards the shame phenomena for therapists because the supervisory relationship is held in a more litigious and market based context resulting in increased 'performance anxiety' for therapists.

Fear

Participants' reactions support the notion that **boundary issues** can provoke fear and anxiety within therapists; something which is documented in the literature (eg Pope and Vasquez, 2016; Reeves, 2011). Despenser (2005; 2007) highlights therapist fear

and their awareness of any threat as important factors to consider when assessing their own safety from physical violence or assault from clients. Similarly, Smith (2003a) identifies fear as important for heightening a counsellor's senses and being alert in session, but warns against it becoming a barrier to effective therapy. Feelings of fear were a common experience for all participants when faced with **boundary issues** in their practice (PA, PB, PC, PD, PE, PF and PG). For example, PB stated *"It's your job, you go in to this, and you know your biggest fear comes straight through the door"* (PB, L625-626). Some participants (particularly PA) reported fear as centrally important to their experiences of **boundary issues**. Further, as PE stated *"…when I first experienced it I was quite anxious"* (PE, L466). However, this did not happen equally for all participants.

For participants in this study shame could often masquerade as fear. It was evident that many of the fears reported by participants were related to shame. For example, some participants in this study were fearful of complaint and litigation from their clients (PB, PD). For example, PB says *"…because somebody along the way will want to, erm, sue you for something that you've done"* (PB, L856-7). In another example, PD states *"so even if you overstep a boundary and some sort of inquiry or tribunal or discipline thing finds that you were wrong"* (PD, L129-31). Smith's (2003a) study into the fear of counsellors found they often feared being separated from a group through disapproval or rejection with a focus on a fear of judgement from supervisors or senior. These fears were directly related to the prospect of litigation and investigation of the participants practice. Therefore, these fears are ultimately about counsellor shame (as detailed earlier).

Boundary Response

Participants were more easily able to articulate how they responded to **boundary issues** in their practice rather than how they defined boundaries. This finding resulted in the researcher mapping out the different **boundary responses** to **boundary issues** by participants (these are detailed fully in the BRM in *chapter six*). However, this section considers some of the key findings about how participants' respond to **boundary issues**.

Boundary Response: Defensive Practice

All participants identified how boundaries were used to protect themselves. Participants used boundaries to protect themselves throughout all aspects of their practice. For example, as PA stated *"I suppose I think automatically about the relationship boundary really, just, erm, on several themes. One – protection, protection of yourself"* (PA, L17-18). A point echoed by PB - *"…for safety, my personal safety"* (PB, L9-10) and PG *"I think they are important for me because it's about keeping me safe"* (PG, L101-2), as well as PF *"…in terms of my own self-care and in looking after myself, I needed to have really firm boundaries, that people didn't step over"* (PF, L342-3). Interestingly, PD broadens the notion of safety by including the importance of keeping everyone safe, identifying that boundaries are *"…designed to keep everybody safe"* (PD, L49).

PE was the participant who referred to her own safety the least although some of her comments could be interpreted to mean she used boundaries for her own protection. PE says *"it's to do with, things like, [pause] if they turn up under the influence of any substances that actually that would breach a boundary. That there is a commitment on both sides in terms of respect"* (PE, L43-46). In this example PE acknowledges that

working within the boundaries is evidence of commitment from both parties and may protect her from 'breaches' such as the client being under the influence of alcohol.

The literature acknowledges that boundaries protect the counsellor as well as the client (BACP, 2015; Kent, 2013; Proctor, 2014) and that counsellor safety can be just as important to consider as that of the client (Despenser, 2005; 2007). Indeed, when faced with **boundary issues** counsellors and therapists reports self-protection as an important aspect of their experience (e.g. Moerman, 2012; Reeves and Mintz, 2001). However, it was still surprising at how dominant this theme was when considering that the majority of the discussion of boundaries in the published literature, although it may discuss counsellor protection, the ultimate focus is on the protection and safety of clients (e.g. BACP, 2016a; Bond, 2015; Kent, 2013; Proctor, 2014). Even when participants mentioned boundaries as protecting both themselves and others they often listed themselves first which suggests they may prioritise their own protection over others. For example, PA states that boundaries are for the *"…protection of yourself and protection of your client"* (PA, L17-8) and PB states they are for *"…my personal safety and the clients personal safety"* (PB, L9-10). The predominant **boundary response** towards **boundary issues** was one of self-protection for the counsellor and this is relayed in the BRM.

This focus on self-protection throughout the interviews indicated that the participants used boundaries as a form of defensive practice with clients. This was a way of defending themselves from unwarranted experiences or events. Barnett (2008) describes defensive practice as "direct protection" (p571) of the therapist. For participants' in this study it was often a reaction to a threat or perceived threat. These threats were often underpinned by feelings of shame and fear.

It was this defensive response from participants which led me to draw comparisons to the 'Amoeba Principle' (Hartman, 2011). This principle underpins the discussion on participants' defensive practice when responding to **boundary issues** and is explored next.

The Amoeba Principle

Hartmann (2011) proposes that boundary changes can be influenced by any threat or danger. This could be in relation to self but also other entities such as professions or organisations. Hartmann uses the analogy of an amoeba which spreads its self out in settled conditions but retracts and toughens its exterior when attacked or threatened, he calls this the Amoeba Principle. This principle can be applied to many **boundary issues**, in therapy. The theory argues if a client perceives an attack on self in therapy (such as the use of an intrusive question from the therapist or an attempt to explore a sensitive topic), they may react by firming up their boundaries. For example, they may try to avoid the question, or for more serious threats they may even consider leaving therapy altogether. Similarly, then this principle may also apply to practitioners. Counsellors may, for example, thicken boundaries in response to clients who challenge them (either directly or indirectly) with a defensive reaction such as denying that there is a problem or distancing themselves from the client. For this principle to be applied successfully there needs to be a threat or perceived threat to the self. The participants' accounts suggest that often the threat to self is feelings of shame or fear (or the potential to feel shame and fear).

A good example to use which is also evident in the participants' interviews is the participants' response to complaint. The 'Amoeba Principle' is useful in considering practitioners response to complaint (either how they respond personally to a complaint

against themselves or their response to complaints in general) because complaints can be viewed as a form of threat to counsellors.

An example of this can be seen in the participants' accounts when PB uses the 'Amoeba Principle' to distance herself from a complainant's story. PB is fearful of complaints from clients and used boundaries to protect herself. *"…you know rules that are set sometimes that unfortunately we have to keep to, because somebody along the way will want to, erm, sue you for something that you've done…"* (PB, L855-57). In this example, PB appears regretful at the need to keep to the 'rules' but feels that they are a necessary aspect of therapy to keep herself safe. PB sees boundaries as important ethical guidelines with which to protect herself from any potential complaints. As she states,

"And the client has gone on to do the same thing to somebody else, so because she kept her boundaries with her its worked out better for her, but again those are one of the big reasons why you have the boundaries…Because no matter what someone is going to accuse you of, in that room between you, nobody can say, and they will always go with the client"

(PB, L565-569)

PB believes that by staying within the clear boundaries of her role (as she reports her colleague did) then she will be safer from any complaint being upheld against her. Her account conflicts with itself as she says that the client will always be believed above the counsellor, yet her colleague seemingly was able to challenge the complaint against her because of the clear boundaries that she put in place. PB believes in the security of clear boundaries with her clients to keep herself safe from complaint although this belief is still underpinned by a fear of any complaint against her.

PB's fears of not being believed appear to mirror those of clients who are fearful of complaining (MIND, 2010). Kearns (2011) suggests that as well as a fear of the

complaints procedure itself a counsellor's reaction to complaint is also based on a more "primitive reaction" (p6) from the counsellor. This, argues Kearns, is about feeling 'caught out' even when the counsellor has done nothing wrong and a presumption that the outside world will never understand what happened in the therapy room. This view is evidenced by PB when she says *"…and they will always go with the client"* (PB, L875). Arguably, this is further evidence of participants responding to **boundary issues** with counsellor shame; that is, of being seen by others to be at fault as a counsellor.

PB appears to distance herself from the client's complaint when repeating this story by questioning the client's emotional state and motivations (Bates, 2006; Gabbard and Hobday, 2012). She states *"'…he has ruined my brain' you know? 'the counsellor has ruined my brain…'"* (PB, L860-861) and *"…and the client has gone on to do the same thing to somebody else"* (PB, L869). This acts as a form of protection for PB, as to whether or not the complaint is truthful, PB is able to avoid any deeper examination of this by laying blame with the client. This is an understandable reaction to criticism (even if it is not against PB herself) particularly when considering how therapists can react with "feelings of shame, fear, persecution, betrayal and anger" ('Chris', 2001, p9) after receiving a complaint. Furthermore, shame can negatively impact upon empathic ability (Tangney, 1991). This is unsurprising because if shame results in a focus on self rather than the other then this creates a boundary (or barrier) between counsellor and client by reducing the counsellor's empathy for the client or at least being less focused on it.

This is the Amoeba Principle in action. Specifically, as PB reacts to the pretence of the complaint against her colleague (i.e. that the practitioner has done something wrong). PB finds this difficult to accept as this would mean that the client was justified in their

complaint. If this is accepted then PB may have to accept that she may too receive complaints against her that could be investigated. This is a threat to self. Rather than consider this possibility PB protects herself by distancing herself from the client's story and there is a thickening of her boundaries. Kearns (2011) suggests that the process of being complained against can result in such intense feelings of shame for the counsellor that it stifles their practice. If this is true, then it is also likely that the fear of complaint could also impact upon the counsellor's ability to practice successfully.

The Amoeba Principle proposes that boundaries will thicken as a way to defend when a person is felt to be under attack from a threat. This effectively is the creation of 'distance' or 'space' between the object being protected and that which is the perceived threat. In terms of the therapeutic encounter this can be considered from both the perspective of the client and the counsellor as a way of protecting themselves.

Arguably, clients are expected to use defence mechanisms within therapy, as they have less information about the therapeutic process than the counsellor, and are possibly therefore, more vulnerable. However, there has been little research into how counsellors' boundaries change in response to any threats to themselves. There is some research which suggests that counsellors and therapists can protect themselves through what could be considered a thickening of boundaries. An example of this is Reeves and Mintz's (2001) work which found that counsellors used informal strategies to cope with clients who expressed suicide ideation by emotionally distancing themselves from sessions. This research suggests that counsellors can respond defensively when they feel under threat and one way this can happen is to raise their defences by a thickening of their boundaries.

There is further evidence of the Amoeba Principle in participants' accounts as they detail how a sense of comfort is important within their practice. Comfort in this respect appears to be a sense of safety and security. It was often related to participants who had established a secure professional or personal identity. For example, PA states that - *"I`ve come to quite a comfortable position with myself"* (PA, L49-50), similarly PC states - *"I feel comfortable with doing that"* (PC, L193).

How comfortable participants felt about either their own or their client's behaviour within the therapy sessions was a key component in making decisions regarding **boundary issues**. For example, PE states *"I didn't doubt myself because I'd already checked it out with my supervisor and I'd already, and the client and I felt comfortable with it"* (PE, L350-351). If participants felt comfortable then they were unlikely to act defensively when presented with **boundary issues**. PA states that setting firm boundaries to make herself comfortable enabled her to not be so defensive. *"…so the boundary of actually releasing yourself from a boundary"* (PA, L782). The participants focus on being comfortable suggests that they had a predilection towards being in this state and were likely to be drawn to it where possible which further supports the 'Amoeba Principle'.

PB highlights what can happen when her sense of comfort was disrupted. In this example PB describes her discomfort when a client sits in the chair that she normally uses. She states *"…the first thing I said to my supervisor was "he sat in my chair" and she said "what did you do?" "I said I felt really uncomfortable I didn't know what to do with myself" and I knew that straight away!"* (PB, L1043-4). PB identifies that logically she should not react in this way, because after all she will just be using a different chair for that particular session. However, PB's sense of comfort is threatened when the routine of her sessions is challenged. PB reacts in surprise and shock towards this

scenario and towards her own emotional response to the situation. It also suggests that the client may have crossed a personal boundary of PB's by changing the previously established routine of the sessions. Although PB does not appear to visibly react to the client in her session her defences are up as she processes how she feels about the client changing seats.

These are just a few examples of many throughout the participants' interviews of the Amoeba Principle in action. It is a defensive reaction to a threat or perceived threat. It is underpinned by using boundaries to defend against the said threat. This aspect of boundaries can be found throughout this thesis and is an important element of the Boundary Response Model (BRM). The principle suggests that the person aims to be in a comfortable state which is free from any threats. Many of the threats in the participants' accounts were underpinned by shame or fear.

This then draws comparisons with the 'triangle of conflict' (Malan, 2007) which is used in psychodynamic therapy to support therapists in creating a client formulation (i.e. an analysis of their difficulties and what is causing them) (Smith and Garforth, 2011). The triangle of conflict is represented by an inverted triangle with the horizontal base at the top with a single angle at the bottom – see figure 3 below. Each angle of the triangle represents one of three elements which are hidden feelings (at the bottom), and anxiety and defence at points at the top. Smith and Garforth (2011) detail the basic elements of this tool and a summary of these are given here. Hidden feelings relate to underlying emotions which are not part of the conscious awareness and are a result of early life experiences. They are at the bottom of the triangle because they are more difficult to access and uncover. Anxiety refers to the person's fears of expressing or uncovering their hidden feelings or urges. Therapists report that they will 'back away' from clients when they feel threatened by feelings of anxiety (Kierski, 2014). Smith

and Garforth state "[a]wareness of the feeling causes anxiety because it conflicts with another need, or an ideal that they hold in their conscious awareness, and so it has

Figure 4: Triangle of Conflict
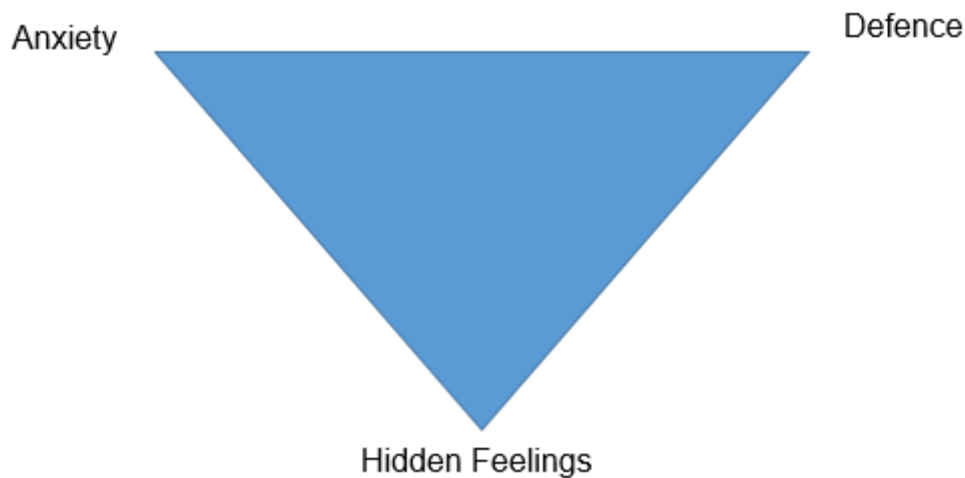
fearful consequences" (2011, p86).

Arguably, this description links very clearly with the descriptions of shame earlier. The defence aspect of this model aims to protect the person from emotional pain by stopping the feelings coming into awareness. Smith and Garforth state "as this process is out of our conscious awareness we are less able to adapt our behaviour to the external world" (2011, p86). For example, participants used boundaries to defend themselves from fear. This was often characterised by participants actively seeking to avoid or remove themselves away from their fears. As PA stated -*"but actually you are in fight or flight"* (PA, L421-2) in a bid to keep themselves safe.

In terms of the triangle of conflict the counsellor is presented with a boundary issue (in PA's case this was extreme client anger). The counsellor feels anxious and therefore defensive which actions her '*fight or flight'* (PA, L422) defence. However, this is masking the hidden feelings that are underlying this response. These could be the fear

of working with this client's emotional state because of the level of intensity (maybe the counsellor does not feel competent to deal with this?) or the counsellor may have unresolved feelings in relation to their own life experiences. Either way the counsellor would feel shame in having to deal with either of these boundary issues and therefore responds defensively. Clearly not all defensive responses will be related to unresolved or hidden feelings. For example, PA also described when she has felt physically threatened by a client and an appropriate reaction to this may well be to exit the counselling session there is no hidden feelings then.

So then, the Amoeba Principle and triangle of conflict are useful in highlighting an aspect of boundaries which feels instinctive (i.e. that boundaries thicken in response to a threat). However, they are limited in that they do not consider the depth of the counsellor's responses to **boundary issues**. It does however highlight the emotional aspect of **boundary experiences** for practitioners in their use of boundaries. I will consider how participants use the Amoeba Principle to respond to a variety of **boundary issues** in later examples but have established the principle here to inform later discussion.

<u>Boundary Feedback</u>

As discussed earlier participants described a variety of thoughts and feelings that occurred once they had responded to a **boundary issue** in their practice. I have labelled this **'boundary feedback'** which included the counsellor's feelings, the perceived feelings of the client as well as any perceived therapeutic benefit to the client. This **boundary feedback** further influences the **boundary attitude** of the participants when dealing with future **boundary issues**, and will therefore also influence how they respond.

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All participants detailed a variety of thoughts and emotional reactions after they had responded to a **boundary issue**. These can be broadly split into both positive and negative types of feedback. Negative **boundary feedback** can be described as further feelings of discomfort or anxiety over the issue because the **boundary response** has not had the desired effect.

For example, in PA's attempts to empathise with her client she states *"I said something like I can't imagine that pain"* (PA, L886). PA receives feedback about her response as she reports *"the person just snapped back at me and said – well don't – just don't then"* (PA, L886-7). This is negative **boundary feedback** because it does not have the desired outcome (presumably to add further depth to the therapeutic relationship).

PA effectively feels shame in front of her client in what she sees as her own clumsy response. *"…were I think yeah – don't dare! You know? Just don't go there!"* (PA, L995). This negative **boundary feedback** reaffirms PA's **boundary attitude** which believes that self-disclosure of her own experiences are unhelpful in grief work. *"…it would be unusual for me to even use that phrase"* (PA, L893-4) and *"that sort of reaffirmed that your own experiences aren't useful in the bereavement work"* (PA, L889-90). This **boundary feedback** continues to inform PA's future **boundary responses** to this **boundary issue**. As she states, showing some humility *"…but it's another lesson, and I think that's important isn't it? That you keep reflecting and learning"* (PA, L926-7).

In contrast, positive **boundary feedback** can be described as the counsellor's thoughts and feelings about how effective their **boundary response** has been. Effectiveness in this sense will depend on what the counsellor was trying to achieve.

As per negative **boundary feedback** this may include the perceived feelings of the client and whether there has been any therapeutic benefit to the client.

PB gives a good example of positive **boundary feedback**. PB's client asks her if she can regularly go outside for a cigarette during her sessions. PB's **boundary response** was to allow this to happen. *"I said "yeah I have no problem with that, just go out, and come in!". And she set that boundary for herself"* (PB, L903-4). PB received positive **boundary feedback** from this as it had a beneficial impact on the counselling sessions. *"…it worked out really well, because the longer we went on, the less time she spent having a cigarette and she'd come back in, because she knew that she could use that time if she felt stressed, or she's get to a place where she couldn't speak"* (PB, L914-7). The client also appeared to feel positively about PB's response. *"…she had said, 'no other people I have worked with have allowed this'"* (PB, L972-3). This positive **boundary feedback** (in conjunction with feedback from her supervisor – *"I talked to my supervisor, and she thought that was fantastic"* (PB, L957-8)) influenced PB in her **boundary attitude** – "s*o I learned a huge thing from there*" (PB, L965).

This section has considered the Boundary Process Map which is evidenced in the participants' accounts. I have detailed new terminology to articulate this model including *Boundary Understanding*, *Boundary Attitude*, *Boundary Experience*, *Boundary Response* and *Boundary Feedback*. I have highlighted some important aspects including the importance of the feelings of shame and fear of a counsellor's **boundary experience** in determining how they will respond to **boundary issues**; including the impact on potentially defensive practice. The next section considers the participants responses to **boundary issues** in more detail through the Boundary Response Model.

Chapter Six: The Boundary Response Model

The Boundary Response Model (BRM) has been constructed from the experiences of qualified and practicing counsellors. This model aims to represent how participants respond to boundary issues within their counselling practice. To understand the model, it is important to understand some of the themes that inform it and the reasons why. The themes which have informed this model as detailed earlier in the previous chapter are: counsellors boundary understanding and boundary attitude towards boundaries is idiosyncratic; a counsellor's boundary attitude is mainly informed by their own values and beliefs; shame and fear are often part of a counsellor's boundary experience when presented with a boundary issue; boundaries are often part of a counsellor's defensive practice; counsellors view boundaries as useful in achieving therapeutic outcomes; and boundaries need to be considered in context.

The BRM has been influenced by both participants' accounts and current literature and theory. This model represents the idiosyncratic nature of participants' understanding and approach to boundaries. The BRM was initially heavily influenced by the participants' defensive reaction to boundary issues. These responses were influenced by experiences of fear and shame that impacted on both the self and professional self. The *Compass of Shame* model (Nathanson, 1992) was used initially to map out the counsellors' responses. However, this model was unable to represent the full detail of participants' responses to boundary issues because it is based on a purely deficit model (i.e. individuals respond defensively to shame and fear).

Point of reflection: Reflecting on my role as researcher I identified that basing a model on a purely deficit approach (i.e. that counsellors use boundaries to respond defensively to shame and fear) needed careful consideration. I was aware that

representing the participant accounts in this way could be considered oppressive and unnecessarily negative. I was also aware that participants may be unhappy that their accounts had been interpreted in this way. I was also aware that although a significant part of the participants experiences there were many aspects of practice which were not 'defensive' and had appeared to be based on high levels of reflection. Therefore, I actively sought to broaden out this original model to include these experiences and offer a balanced view of the participants' responses. Through this process I identified that participants not only respond defensively to boundary issues but had other types of response. For example, participants often directly engaged with boundary issues particularly when it was something that they had dealt with previously. Therefore, the BRM was extended to include another four responses.

The eight distinct boundary responses as detailed by participants were as follows: Protect Other; Avoidance; Attack Self; Challenge; Attack Other; Engagement; Protect Self and Withdraw. These boundary responses are represented on a directional diagram to represent that they are distinct responses which indicate how the counsellor is responding to the specific boundary issue see figure 4 below. Each of these responses is characterised by certain elements and is evidenced in the participants' accounts.
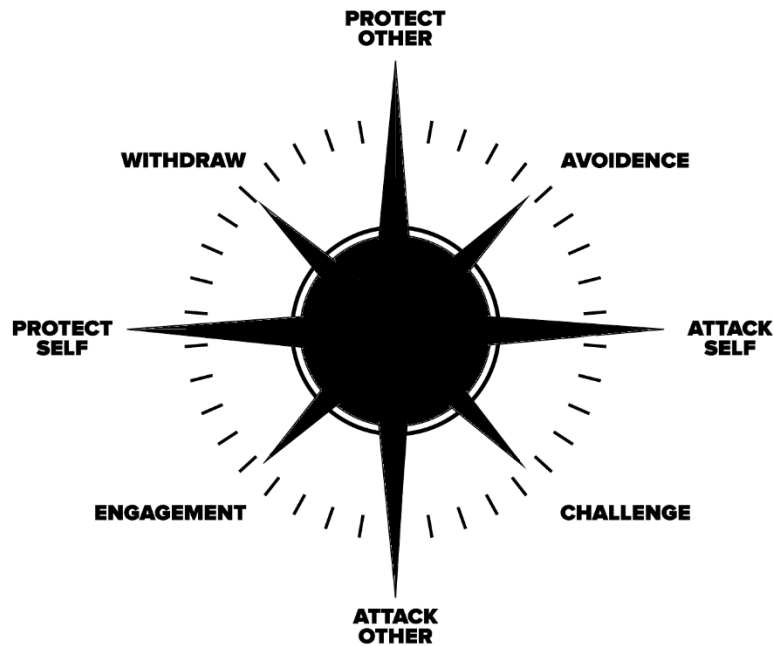
Figure 5: Boundary Response Model - Counsellors' Response to Boundary Issues

These responses have no value judgement placed against them. This means that they can be considered either good or bad practice for counsellors. The one response which may be considered bad practice would be the 'attack other' response however I will discuss this in detail further on.

Although the responses are detailed as distinct with characteristics of their own, there may be overlap between any two responses and they are not designed to be prescriptive but to help further discussion about boundaries. Each response can also be broadly viewed as the contrasting response to their counterpart on the other side of the model. For example, the attack-other and protect-other responses can be viewed as oppositional responses on the model. The characteristics of each response are summarised in table 4 which can be found in *Appendix H, p407*. Therefore, I will explore the common characteristics of each of the responses from the model.

Protect Other – Attack Other

<u>Protect Other:</u>

The first point on the BRM is the 'protect other' response. Participants often identified boundaries as an important aspect of protecting others. For example, PA stated *"…so it is about … protection of the other person"* (PA, L35-36). Protection of clients was usually the 'other' although sometimes the participants identified other groups to protect such as safeguarding children. This is illustrated by PB as she comments *"…he was telling me stuff, that warranted child protection services were trying to get more evidence (inaudible) and ironically I got the other end of it from him. But it was hard because I sat there with a gut feeling that there was a problem"* (PB, L685-9).

Participants also identified the protection of colleagues, illustrated by PD who stated - *"so although boundaries are absolutely vital, but I think when we judge people, our peers and supervisees in terms of boundaries we have got to be forgiving as well"* (PD, L135-7). However, overall the 'other' was usually their clients.

The 'protect-other' response has been placed at the head of the model because it should be one of the main priorities of counsellors to ensure that their clients are protected and safe whilst in counselling (BACP, 2016a; Bond, 2015; Kent, 2013). It arises when the participants identified a threat to the client and this invoked a need for them to protect them. The protect other response is delivered by participants when they perceive no threat to themselves. This ensures that they can focus on their client's issue and not be distracted by defending themselves. This decision is based on the level of empathy the counsellor has towards the client and the counsellor's confidence in being able to protect them successfully. It is a reflective response to the issue at hand (rather than reactionary) and involves a thickening of boundaries around the client to protect them and offer them security. It is a defensive reaction as the

counsellor is trying to defend the client and keep them safe. The counsellor acknowledges and is aware of the boundary issue at hand and may have some uncomfortable feelings about the threat to the client. The counsellor may even be fearful for the client. Despite their concern the counsellor is still fully emotionally available to the client offering what could be called an instinctively maternal and protective response towards the client.

There were numerous ways that participants identified how boundaries could protect their clients. For example, by avoiding exploitation and abuse or enabling the counsellor to have set of guidelines to work to. However, the protect-other response on the BRM is not the same as the general protective notion of boundaries but a specific reaction to an issue raised within the counselling relationship and is explored in an example below.

One example of the protect-other response is given by PC who states,

"If somebody comes, and I know I haven't got a client after and there is a particular point we are talking about and it is really intense moment, I just think, just let them carry on and it doesn't matter and I try and ... I go with that really. So I think it is good to be able to break it occasionally"

(PC, L227-30)

In this example PC is presented with a specific boundary issue – whether to allow her session with the client to run over the time. PC sees no threat to herself – *"it doesn't matter"* (PC, L229), but does identify a threat to the client which is the risk of stopping them short during an important moment – *"it is really intense moment"* (PC, L228). PC is empathetic towards the client – *"I just think, just let them carry on"* (PC, L228-9). PC has reflected on how she approaches this issue in general as she says – *"I think it is good to be able to break it occasionally"* (PC, L230). PC is aware of the issue and has

reflected on how to limit the impact on others – "*I know I haven't got a client after"* (PC, L227*)*. PC is therefore emotionally available to the client and is aiming to protect them.

There is not an obvious thickening of boundaries in this example but PC is extending the time boundaries of this session to enable the client to fully express themselves and hold them safely. Note here that there is no judgement placed on whether PC should or should not have allow extra time in her sessions. This judgement will depend on what the actual (rather than intended) benefit is for the client. Arguably, shame may be considered an aspect of this experience. For PC may feel that she is unable to stop the client mid-flow without feeling embarrassed. However, the reflected comments highlighted previously suggests that her response is a genuine attempt at protecting the client rather than avoid any potential feelings of shame (although she is likely to achieve this also).

Attack Other:

The opposite point to the protect-other response on the BRM is the 'attack other' response. This response was not directly mentioned by the participants in this study (rather there were inferences to it). As mentioned earlier it could be considered extremely bad practice if it was directed at the client because of its extremely hostile nature. However, 'attack-other' response can also be used to describe an 'attack' towards other people or organisations and not necessarily the client for example the organisation the counsellor works for, the profession or a colleague. Attack in this sense can mean any form of criticism or hostility.

The attack-other response is at the opposite point of the BRM from the protect-other response because it is the exact opposite in terms of the reaction it represents. Within Nathanson's (1992) *Compass of Shame* model the attack other response occurs when

avoidance has not been enough, or has been unable to help. It is an externalisation of the shame affect aimed at blaming others (Nathanson, 1992).

The attack-other response in the BRM model is invoked when a counsellor has a conscious or unconscious threat directed at the self. The nature of this threat can vary as detailed earlier. However, it can invoke intense feelings of fear or shame in the counsellor and potentially feelings of incompetence. The counsellor wishes to 'shake off' these feelings and so turns on the offensive and attacks the client. This would usually include a thickening of boundaries around themselves as the counsellor attempts to ward off the unwanted and uncomfortable feelings (by thickening I mean the counsellor attempts to emotionally distance themselves from the client). This is a quick and immediate response to the client as the counsellor responds in anger and fear at the perceived attack on their emotional selves. Initially there is no threat to the client but the counsellor creates one by attacking the client.

If I consider 'other' in this context to be the client then there is little reference to the attack other response in the participants' transcripts. PA refers to '*fight or flight*' (PA, L422) when talking about her fear of physical assault by her clients. However, this is a rare mention in the transcripts. This is unsurprising as counsellors should not be attacking their clients when experiencing feelings of fear or shame in therapy.

However, if I broaden the definition of what constitutes 'other' within the therapy context beyond understanding it as a person, we can see that participants do have an attack other response in defending themselves against shame. For example, 'other' could relate to the organisations that participants work for or rules that they are supposed to adhere to.

One example from the transcripts is given by PB, she evidences an attack-other response when she describes how she does not want to adhere to the rule of not acknowledging clients outside of her sessions. PB says *"now the doctor's office their rule was that if you see somebody out then you ignore them, well I think that is inhumane, that's ridiculous, I said no, I`m not going to do that"* (PB, L1177-9).

In this example, we can see the attack-other *and* protect-other response in action. PB has been given the rule by the GP surgery to ignore her clients when she sees them outside of her sessions. This makes PB feel uncomfortable. PB imagines feelings of shame (i.e. she is embarrassed) as she ignores her client in the street after bumping in to them. PB thinks this is '*inhumane*' and '*ridiculous*'. PB cannot avoid this dilemma because she either acknowledges her client in the street and ignores the GP rule, or accepts the rule and therefore experiences the feelings of shame. The threat to PB is her feelings of shame when seeing the client. PB is angry that she has been asked to do this and responds with an attack towards the GP surgery, she says *"I said no, I`m not going to do that"* (PB, L1179). PB distances herself from the GP surgery and the rules they have specified. Arguably this is also a protect-other response as PB attempts to protect the client from potentially embarrassment from being 'ignore[d]' although PB could have covered the requirements of the GP surgery in her client contract. Which suggests that this response was more about protecting herself rather than her client.

Evidence of the attack-other response can also be found in the literature. Mackenzie (1996), a counsellor, describes a workplace in a GP surgery which is under unlimited and unbounded demands and this results in anxiety in its employee's. This anxiety manifests itself in paranoid defence mechanisms against an unknown 'enemy'. This is the attack-other response acted out at the organisational level. Mackenzie describes

the workplace as lacking in boundaries as there is a struggle between different practitioners in the GP surgery (e.g. counsellors, speech therapists etc) for resources (e.g. space, funding etc). This anxiety and unclear boundaries results in practitioners searching for an 'enemy' to focus their displaced anger and frustration.

The attack-other response can also be seen from therapists who abuse their clients. The therapist attempts to blame the victim (they are mad or bad) rather than experience the shame of their act or the humiliation of being found out (McNulty, Ogden and Warren, 2011). None of the participants in this study reported any behaviour which could be considered abusive. Nevertheless, the attack-other response is important to highlight as a boundary response to boundary issues for counsellors.

Avoidance – Engagement
Avoidance

The avoidance response of the BRM is summarised as the counsellor avoiding the boundary issue that presents itself in the counselling relationship. It was evidenced in most of the participants' accounts. The avoidance response is not necessarily a negative event. However, the avoidance response is characterised by a lack of awareness by the counsellor. The threat is often unconscious to the counsellor, they may be aware for example that there is a boundary issue to deal with but are not consciously aware of the threat that this poses to either themselves or the client. The threat can invoke or stir up feelings of incompetence in the counsellor, and/or feelings of fear or shame. However, these feelings are unlikely to be intense feelings (which would invoke a more immediate and sudden reaction). Feelings are more likely to present as slight uncomfortableness or a feeling that something is not quite right in the session but the counsellor is unclear what this feeling is. In Nathanson's (1992) model

it is characterised by slow and deliberate movement away from an uncomfortable situation. The individual is attempting to protect their personal world, through either fooling themselves or others (or both). For Nathanson (1992) mild avoidance can be considered 'normal'. The Boundary Response Model defines the avoidance response as an evading of the boundary issue in therapy by the counsellor. In Nathanson's (1992) model the avoidance response aims to reduce, minimise or 'shake off' the shame affect, whereas in this model the counsellor aims to minimise or shake off the perceived threat which may indeed be feelings of shame. However, it may also be other types of threat towards the counsellor or the client. This is a defensive reaction and it is more likely to be in defence of the counsellor rather than the client. It results in a thickening of boundaries usually around the self which means an emotional distancing from the client through a denial of the problem – effectively avoiding the issue. In the BRM it is characterised by a lack of confidence in the practitioner surrounding the particular issue. It may result in an emotional shift away from the client, but it also has the potential to push the counsellor into collusion with the client.

There are numerous examples of the avoidance response throughout the participants' accounts. An example I highlighted earlier is of PG taking a client out for an ice-cream. PG did not tell anyone of this action. I will look at this example in more detail here and identify how it fits into the avoidance response.

"There was one occasion at the end of the first year were, it was quite a hot day outside and we had kind of met up and it was outside and we had kind of met up and we were talking and I said to her why don't we go and get an ice-cream at ********'s. ********'s is just outside ******** and is an ice-cream place, and we did, we went and had an ice-cream, and I know that eating in front of somebody else was a big big thing for her, so we drove in the car, she was 18 by the way, this was, this client was 18. We drove in the car and it was ok to eat it as long as we sat side by side and she looked out and I looked out and I wasn't actually facing her, and so we did that, and I say that is my biggest breaking of any boundary. I don't know what college would say about that and I never asked anybody and had to say I am telling you this now that I never sought permission to do it, I kind of felt, I felt justified in my actions, I was happy, I would have

been happy to defend, we were kind of gone for say three quarters of an hour, no more than that, I wouldn't have forced her to go, and I had to kind of work intuitively and kind of guessing that this was something that she kind of felt ok about, and it was an opportunity for her to escape the confines of this place, at a time when she felt quite lost and quite isolated in the place so it was, so we did that"

<div align="right">(PG, L145-64)</div>

Before identifying why this fits into the avoidance response on the BRM it is important to identify which issue we are discussing. The avoidance response relates to PG's lack of disclosure about her actions rather than the breaking of the boundary per se. I would see PG taking the client for an ice-cream as an engagement response (and I discuss it in that section of this chapter).

PG avoids disclosing her breaking of a boundary with her client. PG talks extensively about her reasons for taking this client for an ice-cream. PG has a variety of reasons and argues that she would be "*happy to defend*" (PG, L158-9) her actions. However, PG does not tell anyone or defend her actions to them. Furthermore, PG avoids discussing this issue with others or seeking permission despite her confidence that it was the right thing to do – "*I felt justified in my actions*" (PG, L158). This suggests that there is a threat to self from disclosing what she has done. This threat is likely to be the possibility of being shamed in front of her colleagues as they perceive her actions to be unprofessional. This suggests that PG also has feelings of incompetence around this issue (despite her protestations otherwise). Arguably, there may also have been a threat to the client if PG had disclosed to others about what she was doing as they may have viewed this as inappropriate and tried to put a stop to it. Usually the avoidance response is characterised by counsellors being unaware of the issue. However, in this case PG is aware that she has avoided speaking to others. She states -"*I don't know what college would say about that and I never asked anybody and had to say I am telling you this now that I never sought permission to do it*" (PG, L155-7).

However, this is clearly an avoidance response because there is no evidence that PG is making a conscious and reflective choice when not disclosing this issue to others. This is evidenced by PG saying - '*I don't know*' (PG, L157) and '*I never asked*' (PG, L158). As per the other responses it is not for this model to decide whether the actions PG took were good or bad practice. This model merely maps out which response participants took in relation to a boundary issue. As you can see from this example sometimes there may be multiple boundary issues which are combined within one example.

<u>Engagement</u>

The engagement response of the BRM is the opposite point on the model to the avoidance response and in many ways, has the opposite characteristics. It can be summarised as the counsellor acknowledging the boundary issue within the therapeutic relationship and attempting to wholly engage with it. To respond in this way the counsellor will perceive no threat to themselves or the other person. The counsellor has confidence in their practice and ability to deal with the issue through a reflective and engaged response underpinned by empathy towards the client. The counsellor will feel comfortable in discussing the boundary issue and this will result in a 'thinning' of boundaries as the counsellor is willing to be open and exposed with the client without a fear of how they will respond. This leads to an open discussion with the client about the issue with the counsellor being emotionally available towards the client. It is also characterised by the counsellor developing awareness of the issue, reflecting on their practice, and responding with confidence.

This response is similar to Spong's (2012) description of how counsellors engage with a client "…by hearing and understanding the client's frame of reference and by

facilitating the client's development towards a less rigid/less conflict-oriented/less defensive position" (Spong, 2012, p123).

PE provides a good example of an engagement response when she discusses the issue of using boundaries to identify the difference between what she is feeling and what the client is bringing to a session.

"I do now, when I first experienced it I was quite anxious, so I was thinking what on earth's the matter with me, I felt fine before what's going on, you know, you have this little conversation with yourself, and at the same time trying to keep everything going. But now I recognise it now, so I am more ready and more able to then go ok that's not me. I know that's not me, that is one of the reasons, why before I have a day of counselling I always go out for a walk because I know then what's me"

<div align="right">(PE, L466-472)</div>

PE describes here a form of self-protection as well as a way of ensuring the efficacy of her practice. It is self-protection because as PE attempts to centre herself before her sessions, she is able to more clearly define '*what's me'* and what is *'not me'*, ensuring that she does not take on other's feelings as her own. It also ensures therapeutic efficacy as PE establishing her own feelings before sessions which enables her to focus on what the client is bringing to the session. This is an engagement response because PE has gradually become aware of the presenting issue, has reflected on the best way to approach it, and developed her confidence in establishing the difference between herself and the client. This enables PE to clarify the boundaries between her and her client. However, it also enables a thinning of boundaries between them as she offers herself more completely with the security of her established self. PE has moved from an anxious feeling when she is unsure why she feels uncomfortable to engaging with that issue by acknowledging what she is feeling. PE does not appear to discuss this with the client but then in this case it

appears that she has no need to as the issue is about her emotional availability and response in her sessions with the client.

If we consider the example given by PG about taking a client for an ice-cream.

"I felt so. I kind of wanted her to, I wanted her to feel connected with the world because she was very disconnected with the world, and I know there was part of me that was playing the rescuer there and I know there was a part and I absolutely put my hands up and own about that, and it was about me wanting something different for her. Because I kind of witnessed her every day lock herself, hide herself away. I mean I knew where she hid in college and other people wouldn't know where she hid in college. I just kind of wanted something else, and we kind of got to the end of the summer and I thought you know, let's just go and get an ice-cream, and it was as simple as that. I`m sure there was a breaking of a boundary there, without a question of a doubt. And I guess I would have had to face the consequences if anyone else became aware of that"

(PG, L168-79)

This is an example of the engagement response. PG perceives no threat to herself or the client through this action (only benefits). There is a potential threat if PG discloses this to others (and PG reacts with an avoidance response to this issue as detailed earlier). PG is confident in her response as she states - 'I felt justified in my actions'. PG has empathy with the client – "*because she was very disconnected with the world*" (PG, L169). PG reflected upon this issue – *"I know there was part of me that was playing the rescuer there and I know there was a part and I absolutely put my hands up and own about that, and it was about me wanting something different for her"* (PG, L169-72). However, PG acknowledges her role in this response and weighed up her reasoning and chooses to complete this action anyway. There does not appear to be an open discussion with the client about why PG would like to take for the ice-cream at the time. However, the client appears to respond to this experience and it is discussed at a later stage. PG notices that this action enables a further depth to their relationship. She says *"…actually when we came to finish and we kind of spoke that was something that she came back to that was an experience that kind of meant*

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something to her. And in relational depth, that I thought enough of her that I would want to do that, and we'd actually want to spend some time together having an ice-cream" (PG, L185-9).

In this response PG is comfortable in her actions she has no fear about the client's response and is emotionally available to her. PG has acknowledged that there is an issue to address, has reflected on her response and engaged with openness and transparency with the client. PG has advised whether she should discuss this issue with others but has engaged with the issue within her practice.

Attack Self- Protect Self
Attack Self

The attack-self response can be summarised as the counsellor berating themselves for their interactions with a client or for the way they have behaved within the therapy session. This response can be characterised by the counsellor having conscious awareness of a threat to the self. This threat may present as fear or shame. The feelings will be intense and be uncomfortable for the counsellor. However, the counsellor will have an acknowledgement of the issue. This will invoke a thickening of boundaries around the self as the counsellor criticises themselves for their mistake which may invoke feelings of incompetence. The counsellor aims to quickly move away from the issue. It can include an emotional distancing of themselves from the client although the counsellor may offer an apology to the client in some circumstances. The response aims to protect the counsellor and on some level it may also protect the client. There can also be an element of self-loathing attached to this response as the counsellor over emphasises the impact of their behaviour on the client.

The attack self-response in the *Compass of Shame* model aims to avoid the isolation of withdrawal, and take control of the shame affect by experiencing the feelings of shame fully (Nathanson, 1992). However, it is important that others know that the person is experiencing this shame, and is a voluntary response aimed at building relationships with others (Nathanson, 1992). In the Boundary Response Model, the attack response is characterised by an awareness (or perception) of error by the counsellor. This results in feelings of shame or guilt, and leads the counsellor to criticise their own practice. There may be elements of reflection, however largely the counsellor is indicating a lack of confidence in their own practice. In the BRM counsellors do not necessarily share the attack on themselves with the client.

Participants in this study often reported an attack-self response when working with boundaries. This was often a reaction to feelings of shame. In one example, PA reported:

"I don't go there, and though recently...the...a...someone lost their partner, I was seeing them afterward in a bereavement session and (pause), I said something quite, it came out as how I wouldn't normally say it, I said something like I can't imagine that pain, the person just snapped back at me and said – well don't – just don't then – and that was really powerful because I thought, yeah how dare I even try, 'cause this is terrible, erm, and that sort of reaffirmed that your own experiences aren't useful in the bereavement work, it doesn't help them to know that you have lost someone and you were traumatised when you were twenty you know whatever, so it was interesting that when I actually left ...I can't imagine the pain you know, it would be unusual for me to even use that phrase, and (clicks fingers) – snap – like that – she said well don't then, don't even go there, erm, and I think, ... I`ve been involved with someone recently who's daughter has died and left a child aged three, and so this person is trying to bring a three year old up, and that's another issue where I think what would happen if I wasn't here if I died and my children were left and it's so immediately painful (light laugh in voice), I just don't go there, but I`ll let myself travel there a bit, but afterwards sometimes, you know to locate that pain, just to help on the identification really, you know? That you don't lose that empathy, and it's so painful that you're just...urghh no, but that phrase that the women said to me – don't – that was another one of these situations that I`ve told you about, were I think yeah – don't dare! You know? Just don't go there!"

(PA, L899-905)

In this example, PA clearly attacks herself as she experiences shame brought about by the client's challenge. The threat to PA is her experience of shame in front of the client it is conscious and PA acknowledges its presence to herself. PA blames herself for comparing the client's situation with her own, and not staying in the client's reality rather than her own. This could be considered feelings of incompetence as she berates herself for doing this – *"just don't go there"* (PA, L905). This would also suggest PA is experiencing counsellor shame as she is confident that she is in the wrong. It was a quick response which is indicated by the 'snap' and challenge from the client. PA is uncomfortable with how she has dealt with this issue as she says - *"it would be unusual for me to even use that phrase"* (PA, L893-4). PA indicates that her response to the client in this situation was about her identifying with her own personal experiences whilst the client was talking – "*that sort of reaffirmed that your own experiences aren't useful in the bereavement work*" (PA, L889-90). When actually what PA was emphasising was that she could *not* imagine the grief, the client was going through. This suggests that PA attempted on some level to distance herself from the client emotionally after this interaction to untangle her own feelings from that of the client. Even though in this example PA attacks self, it is unclear if, as per Nathanson's (1992) model proposes, whether the client knew the counsellor was experiencing this shame. Certainly, PA appears to have experienced this feeling fully, as she is able to acknowledge and fully explain the embarrassment she suffered regarding her comments. However, her response appears to be much more internalised than Nathanson's (1992) model suggests. PA remains emotionally available to the client and is not fearful of this challenge.

<u>Protect Self</u>

The theme of self-protection for the counsellor runs throughout this thesis. There are elements of self-protection which are highlighted throughout the Boundary Response Model (for example withdrawal, avoidance, and attack-other can all be forms of self-protection for the counsellor). However, the 'protect-self' response can be characterised by a full awareness of a threat to self and the counsellor identifying the need to protect the self this is a conscious rather than unconscious act. The response is not necessarily the right or even best response to the issue but one that the counsellor has come to after a reflective process.

The protect-self response means the counsellor will have reflected on the best way to keep themselves safe, and acknowledged the route they need to take. This often results in a conscious thickening of defences or boundaries around the self (for example an emotional distancing of the self from the client) or around the therapy (for example a tightening up of expectations of the client). This may be evidenced through the Amoeba Principle or it may be a prepared plan of action or intervention. There is no perceived threat to the client. The counsellor is confident in their response and has reflected on the issue. It is a defensive reaction to ensure the safety of the counsellor. However, the counsellor is still emotionally available to the client and empathetic towards the client despite their own fears.

PG has a particularly poignant example of the self-protect response working over the longer rather than the short term.

"I try and do that. But I have to say that's, I`m saying that to you, and that's easy with some clients than others because if I feel deeply touched and I guess some clients do touch me more perhaps than other times, you know, extreme vulnerability, real hopelessness, and loss. Kind of really really touches me. And then I know that I carry them outside that session. And that's something over the years that I`ve learnt to kind of manage with myself much better because I know when I first started in all of this,

particularly when I was at the doctors practice, I could carry them for quite a few days afterwards and I would be worried, and I would be concerned. Sometimes what I came to know was that when I came back to them the next week and I was kind of still carrying them from that week, and over the course of that week as we know in counselling a lot can change and move and be different and I was kind of still stuck back here somewhere, and I'd come into the room with them and find they are somewhere else"

<div align="right">(PG, L286-300)</div>

This is the self-protect response as PG evidences that there is a threat to the self in the form of her vulnerability to needy or helpless clients –"*I know that I carry them outside the session"* (PG, L290). PG is conscious of this threat. PG has become confident (over time) in acknowledging this threat to self and being able to manage it as effectively as she can –*"that's something over the years that I`ve learnt to kind of manage with myself much better"* (PG, L291-2). Her response is reflective over time rather than reactionary in the moment. The very nature of this issue means that PG is empathising with her client. However, PG acknowledges that there is a thickening of her boundaries around the self as she aims to protect herself from carrying the client's feelings week to week. There also becomes a thickening around the therapy itself as PG forces herself to consider the interaction between herself and the client as in the moment as she realises that the client moves on from session to session so why should not she? PG's reaction is defensive in that she looks to protect herself but it has been learnt through the gradual experience of dealing it with on numerous occasions. PG identifies that this creates uncomfortable feelings in her and later in her discussion of this issue relays an anxiety about protecting herself from needy or helpless clients as she is fearful that she cannot say no to such a depth of need. Despite this fear she is still emotionally available and responsive to the clients.

Challenge – Withdraw

<u>Challenge</u>

The challenge response in the BRM can be considered (broadly speaking) the opposite of the withdrawal response (discussed later). The counsellor becomes aware of a threat to themselves, the client or the therapy itself and consciously decides to raise it as an issue to discuss. Rather than disengage from the boundary issue (as in the withdrawal response) the counsellor actually participates in an open encounter with the client about it. This does not necessarily mean challenging the client (although this is possible), but includes direct and open discussion of the presenting boundary issue. This serves the purpose of acknowledging the issue and giving the client opportunity to respond. PF states it is *"when I need to say, "…that's enough". You've kind of stepped, you've kind of stepped a bit too far over where I want you to step"* (PF, L356-359). The challenge response is triggered by the counsellor's uncomfortable feelings and is a reaction to a difficulty or inconsistency in the therapy session. This response is not fuelled by shame or fear, but is possibly an issue of ethics or an attempt at clarity. The challenge response can take a variety of forms, the most obvious is the counsellor challenging a client's behaviour in therapy, or bringing an issue into the open. The counsellor will remain emotionally available to the client during the challenge response and continue to offer empathy. There may be a thickening of the boundary around the therapy process as the counsellor attempts to hold the therapy secure whilst discussing the issue. The counsellor is very much involved in this discussion as it is a dynamic interaction which the counsellor deals with confidently and transparently (i.e. there is no hidden meaning or agenda).

A good example of the challenge response is explained by PD as he challenges a client who expresses judgemental views.

"I also think there are behavioural boundaries in the relationship too. How do I deal with a client who is wholly inappropriate, who is a misogynist or a racist? They are clearly crossing a boundary and it has to be dealt with and that is a very strict unmoveable boundary for me that I have to watch and behave appropriately in terms of the isms. … Yes. Yes I have said to somebody 'just stop there, I want you repeat what you said and listen to yourself very carefully' and before they start to speak they think 'oh'. So they say it, this person has repeated it, and I say 'now take a moment and tell me how you feel?' And it was a big moment for them. And they said 'wow, I would never have thought I was that sort of person' and I said, well we need to perhaps work on that at some stage. What is lying underneath?"

(PD, L221-234)

In this example PD is conscious of a potential threat to the therapy which has arisen through his own uncomfortable feelings – *"they are clearly crossing a boundary"* (PD, L223). PD is confident in his response – *"that is a very strict unmoveable boundary for me"* (PD, L224-5) and determined that he must react – *"that I have to watch and behave appropriately in terms of the isms"* (PD, L225). PD's response is reflective and involved, he does not shy away from trying to deal with it and even asks the question *'how do I deal with a client who is wholly inappropriate, who is misogynist or a racist?'* There is a thickening of the boundaries of the therapy as PD focuses the client upon the specific issue of their comments – *"'just stop there, I want you repeat what you said and listen to yourself very carefully"* (PD, L228-9). PD is still empathetic towards the client's needs and offers them a moment of self-reflection – *"So they say it, this person has repeated it, and I say 'no take a moment and tell me how you feel?"* (PD, L230-1). PD is not fearful of challenging the client in this way and is still emotionally available. It is an open challenge of the issue of racism without any hidden meaning but a challenge that is also handled sensitively.

In this example, PD stays in control by asking the client to think about the words they are using, and exploring the client's thoughts and feelings on their own judgements. This suggests a level of comfort from PD in challenging racism, compared to what appears to be discomfort when confronted with a client who may be flirtatious say (see later discussion of the erotic in therapy). In both examples, it is important for PD to stay in control of what is happening but they are approached in very different ways. I would argue depending on his level of comfort he has in dealing with each particular issue.

Another example of the challenge response comes from PA, when she describes how she would respond if a client overstepped boundaries with their emotional presentation in a session.

"…and that has to be a formal contract of behaviour really, that is really useful if someone becomes very angry, because you can refer back to the rules that you set at the beginning on norms and behaviours, again pull that from all my training and I think that actually it is a nice useful tool really to start off any relationship with, and you can refer back and say, "I'm feeling uncomfortable this is not how we set it, I`m sorry I am not going to continue if you carry on really", it's a way out, of er a situation sometimes and I`ve been under threat several times, erm, over the years"

(PA, L351-359)

In this example PA has pre-empted the boundary issue possibly because she has already been "*under threat several times … over the years*" (PA, L358-9). For PA she is consciously aware of a threat to herself from the client that is "*if someone becomes very angry*" (PA, L351). If we set aside for one moment whether intense anger needs to be challenged in a therapy session for PA this is deemed a threat to self. PA has experienced this on other occasions, has reflected on this issue and is confident that the best way to deal with this is through setting her expectations out at the start of the sessions – "*because you can refer back to the rules that you set at the beginning*" (PA, L352-3). PA identifies her discomfort – "*I`m feeling uncomfortable this is not how we*

set it" (PA, L356). In this example, it could be argued that PA is not able to offer continued emotional availability to the client as she is challenging the intensity of the emotion that they are bringing into the therapy session. Bond (2015) argues that there is no ethical imperative that counsellors need to continue to work with clients who evoke a sense of threat to them even if that threat is purely perceived rather than real. PA is open and transparent about challenging this issue and offering the client a choice about how they respond which is therefore a challenge response. It could be that PA offers this challenge as a way of moving the therapy forward. However, it is also likely that PA is also aiming to protect herself in this

Spong (2012) explored counsellors' perceptions of challenging clients prejudices although notably did not identify this as a boundary related issue. Spong found that counsellors reported three potential ways to respond when confronted with prejudices from clients in their sessions. These were: to challenge, not to challenge or to exit the relationship. These responses could be compared to the challenge, avoid and withdrawal boundary responses noted in this current study. Participants of Spong's (2012) study reported the benefits of challenging or not challenging the prejudice from the client, or alternatively exiting the relationship altogether. What is interesting to note about these reasons is that participants identified benefits to both the client and the therapist when challenging prejudice (including self-protection of the therapist). Participants identified more reasons that were beneficial for the therapist by exiting the relationship altogether whereas reasons for not challenging the prejudice were more beneficial for the client. Therapist fear or the avoidance of shame was not highlighted as a potential reason for not challenging the client. Indeed Spong's (2012) research resulted in what appears to be 'acceptable' reasons for responding to this challenge.

Although Spong (2012) does highlight the tension raised in this study between participants' responsibility to their clients and to themselves when challenging clients.

<u>Withdraw</u>

In the Boundary Response Model (BRM) presented in this study the withdrawal response is triggered by the counsellor. It is an unconscious reaction to either a real or perceived threat to themselves or the client. There is no value judgement placed upon this response (i.e. is it right or wrong). Withdrawal can take a variety of forms, the most obvious is the counsellor ending the therapy with the client, becoming emotionally distant with them or bringing an individual session to a close.

In Nathanson's (1992) *Compass of Shame* model of shame the withdrawal response has two purposes, it gives the individual time to recover and can protect them from further hurt (i.e. affect reduction and affect avoidance). Therefore, it minimises the experiences of shame. It can be swift, and occasional and appears on a spectrum, for example an individual may avert their gaze through to chronic depression. Mild withdrawal according to Nathanson (1992), can be considered 'normal' in response to some experiences of shame.

The withdrawal response of the BRM is characterised by the counsellor's feelings of incompetence in dealing with the presenting issue. The counsellor's boundary response is quick and sudden in response to the counsellor's uncomfortable feelings (usually intense feelings of either fear or shame). This aims to move the counsellor away from directly dealing with the boundary issue. The counsellor is often in denial about the problem and does not consciously acknowledge it. This is a defensive reaction which can involve a thickening of boundaries around the self or the client (that is an emotionally distancing or reduction in engagement with the client). In practice,

this can present as the counsellor withdrawing themselves from the session or stopping the sessions completely.

For example, PA discusses the possibility of a withdrawal response when faced with intense grief and was frightened of the physical presence of their client.

"So, I never feel that I haven't got the power to control it, I think I have been very lucky maybe as well, and also the nature of the work maybe, has made it, twice I have felt completely intimidated with a finger in my face…and, potentially they could of hit me, you know, erm, and I've removed myself physically first, and kept very calm and used a lot of my skills to just tone the conversation down, and resolved it, each time we've not actually ended the session we've resolved it, erm, and that was in extreme grief one ... one lady had lost her daughter ... her daughter had died and she had only just found out and she didn't know where...she didn't know where to put herself, physically, just absolutely lost it and erm, and I did fear for myself at that point I thought she was going to hit me"

(PA, L631-4)

In this example PA has a threat to herself from her client – *"I have felt completely intimidated with a finger in my face"* (PA, L633-4). This threat moves between the conscious and the unconscious as PA states that – *"I did fear for myself at that point"* (PA, L643) and *"I never feel that I haven't got the power to control it"* (PA, L631). In these two statements PA contradicts herself and suggests that she does not want to admit to her fear of her clients and suggests an element of denial. This is evidenced further later in the interview when she states that *"…but what I didn't realise is, and even now talking to you, would be how much a part of that would be on my mind"* (PA, L416-7). PA is uncomfortable when experiencing these intense emotions from clients and as these appear to suggest to PA that there is some form of physical threat on its way. PA is prepared to withdraw if needed she states – *"I've removed myself physically first"* (PA, L636-7). However, PA reports that she has not needed to take the withdrawal response she states – *"each time we've not actually ended the session we've resolved it"* (PA, L638-9). PA is prepared for a withdrawal response and appears

to have unconscious fears surrounding the presentation of her clients and the intensity of their feelings.

Summary

The Boundary Response Model (BRM) has been detailed in this section. It is constructed from the experiences of qualified and practicing counsellors. This model represents how counsellor participants' respond to boundary issues within their practice. This model has been informed by the following findings: counsellors understanding and attitude towards boundaries is idiosyncratic; a counsellor's boundary attitude is mainly informed by their own values and beliefs; counsellor's boundary experience when presented with a boundary issue is often underpinned by shame and fear; boundaries are part of a counsellor's defensive practice; counsellors view boundaries as useful in achieving therapeutic outcomes; and boundaries need to be considered in context.

I have outlined the Boundary Response Mode (BRM) and the different characteristics that exist for each boundary response. I have given at least one example of each within the previous section. In this next section I have taken some examples of boundary issues which have been shared by multiple participants' and explore each of them using the BRM. This endeavour will be used to highlight how the same boundary issue can be responded to differently by different counsellors or by the same counsellor but at different times. This exercise will also highlight how the model is useful in developing the discussion around boundaries and how it can be used in practice to develop counsellors understanding and approach to boundaries issues. The three examples discussed here are: the erotic in therapy; charging clients for counselling and confidentiality.

Discussing the erotic in therapy

Mann (2015) argues that majority of therapists have an instinctive wish to avoid discussing the erotic in therapy. Certainly, some participants (PB, PC and PD) in this study attempted to avoid this discussion with clients. This avoidance, Mann argues, is a form of self-protection which works towards keeping the status quo. Mollon (2005) states that "because sexuality is threatening and frightening, it is repressed or banished from discourse" (Mollon, 2005, p167-8). Shame and embarrassment can be felt by therapists who encounter sexual attraction within therapy (Rodgers, 2011). Certainly, some participants of this study were uncomfortable in exploring potential issues of attraction with clients and aimed to protect themselves from feelings of shame. Shame may be felt by therapists who feel inadequately prepared to work with the sexual in therapy (Kearns, 2011), which could also be related to feelings of incompetence. Whereas therapists may also be fearful of unethical practice, if they engage with the erotic in therapy, through a lack of competence in that area (Rodgers, 2011).

PD is the only participant who refers to client/counsellor attraction directly. *"…if it is male and female because it is a hugely intimate relationship but there is a boundary there"* (PD, L206-7). As detailed earlier PD's general attitude towards boundaries is one of rigidity. That is he believes in rigid inflexible boundaries that cannot be crossed. However, he allows himself flexibility within that frame to support him building intimacy with his clients. PD is presented with the issue of discussing the erotic in therapy, this will impact on the therapeutic encounter and can therefore be labelled a boundary issue.

When faced with this boundary issue PD's account suggests that he experiences shame or is apprehensive about feeling shame.

"Of course, clients cross boundaries too. I say now regularly in supervision, as counsellors, you have to be aware and monitor this closely the demeanour of clients as your sessions roll on. Particularly if it is male and female because it is a hugely intimate relationship but there is a boundary there, it is a professional relationship. Yes it is very intimate. But clients will often read the message wrong and start to build up an emotional response to you as the counsellor which starts to drift into inappropriateness. That is often displayed in dress, grooming and demeanour. To stop the client crossing that boundary the counsellor has a responsibility to do something and for me when I started to learn about good endings, that is when I realised there is a way to deal with it. Once somebody starts to behave in a way like that, their confidence is back, they are believing in themselves, they are dressing confidently, and grooming themselves, so there is an ending in sight. So you bring your counselling to a close. At satisfactory ending without anybody crossing a boundary. Now you talk about experience but that didn't come to me without working with one or two people who were about to cross that boundary otherwise why would I think about it."

(PD, L203-21)

PD relates his use of endings as a way of protecting the client from doing anything inappropriate, and crossing a boundary. Presumably, this means preventing the client from acting on their feelings of attraction to the therapist. However, it is unclear if these feelings are there, because they are never apparently addressed or explored. This suggests that PD unconscious fears surrounding the client's attraction to him are what is really threatening – *"Yes it is very intimate. But clients will often read the message wrong and start to build up an emotional response to you as the counsellor which starts to drift into inappropriateness. That is often displayed in dress, grooming and demeanour'. It is the client that who is building an emotional response that is moving towards 'inappropriateness"* (PD, L208-10). Certainly, it is inappropriate for counsellors to act upon their own sexual desires for a client (BACP, 2015; Bond, 2015). However, it is not necessarily inappropriate for clients to have these types of feelings. Although PD has some acknowledgement that there may be a threat from the client in breaking a boundary – *"clients cross boundaries too"* (PD, L203-4). PD is fearful of this happening. *"I say now regularly in supervision, as counsellors, you have to be aware and monitor this closely the demeanour of clients as your sessions roll on"* (PD, L204-

6). PD places responsibility on himself for not letting this happen – *"to stop the client crossing that boundary the counsellor has a responsibility to do something"* (PD, L211-2). However, PD has what can be described as a defensive reaction as he attempts to stop this crossing from ever happening or being even being acknowledged in the therapy sessions. This is a withdrawal rather than an avoidance response because PD works towards ending the service with the client – *"so you bring your counselling to a close"* (PD, L217). PD identifies endings with clients as a way of avoiding the crossing of a boundary – *"At satisfactory ending without anybody crossing a boundary"* (PD, L217-8). However, 'satisfactory ending' feels as if it is about being satisfactory for PD rather than the client because it is based on PD's feelings and motivations rather than the clients. This is interesting when we consider inappropriate endings and breaks are a common complaint from clients (Khele, Symons & Wheeler, 2008); and a key factor in a client's consideration of a 'good enough' ending is that it is made jointly with the therapist themselves (Råbu, Binder and Haavind, 2013).

This could be argued to be an example of the withdrawal response on the BRM and is triggered through the shame of possible client/counsellor attraction or the discussion of this in therapy. PD appears to make an assumption about this attraction, and relates it to therapeutic outcome. PD hypothesises that because the client takes a greater pride in their appearance this may be dually associated with both therapist attraction from the client and evidence that the therapy has been successful. However, there is no evidence in this account that this is true. It may be that there is an increase in confidence from the client but this may not necessarily relate to therapist attraction.

Point of reflection: Interestingly, this is explained in the context of therapy with female clients, rather than male, which may indicate that PD may presume heterosexual tendencies in his clients. Rodgers (2011) suggests that research should be expanded

to investigate the various combinations of sexual orientation between therapist and client to give a greater understanding of the erotic in therapy.

If we consider PD's boundary feedback in this scenario. His client shows indications that they are feeling more confident and have changed their appearance. PD believes this may indicate a therapeutic breakthrough and evidence that therapy is succeeding. PD is also concerned that the client may have started to have erotic or affectionate feelings towards him and therefore concludes the therapy must end. This happens and PD's boundary feedback is that the client has left happy, more confident and that there was no need to approach the issue of attraction or the erotic. This then feeds into his boundary attitude. However, the boundary feedback in this scenario is based on PD's suspicions rather than actual evidence or openness in the sessions.

If we explore PD's account further there is some further indication that his response to this boundary issue is related to the shame-affect. *"I have had conversations with three lady counsellors who have had boundaries seriously crossed in terms of sexuality. Some have been absolutely outrageous and others have been very creepy"* (PD, L299-301).

PD links these female counsellors experience with his own – *"That kind of boundary is similar"* (PD, L318). Their stories certainly reflect an element of shame as these therapists are asked directly or indirectly to participate in a sexual relationship or flirtation with their client. *"The creepy one was … 'have I ever told you how nice your legs look in those shoes?' well this poor lady freaked out, cause it was so kind of covert"* (PD, L310-2). The gravity that PD associates with these requests from clients is clear when he says – *"that is a massive, it is the biggest boundary isn't it. That is massive"* (PD, L309).

It appears that PD associates shame with his experiences also. Considering Lewis (2003) phenomenological description of shame we can see similarities. PD wishes to escape away from the therapy with these clients and has clear discomfort in continuing therapy with clients who may have a sexual attraction towards him. *"That kind of boundary is similar to the one where I can see a non-professional attraction growing in a female client and I bring it to an end"* (PD, L 318-20). Furthermore, PD may be experiencing some level of shame at the thought of the client crossing that boundary, but is protecting himself from being the object of that shame by removing the possibility of that happening. This is a thickening of boundaries as per the Amoeba Principle. This is further evidenced when PD says - *"But that is kind of … it is not a big fracture if you do it properly. But when someone actually says … 'can we have an affair?'"* (PD, L320-2). In this quote PD is interacting that he can avoid the discussion with the client without a 'big fracture'. However, if a client actually asks the question (can we have an affair?) there is no escape from having to directly respond to this request and feeling the shame affect.

If we relate this to the BRM model, we can label PD's response as a withdrawal response in relation to the discussion of attraction in therapy. PD withdraws himself (and the client) from the therapy process. PD argues this is for the protection of the client. However, without assessing the accuracy of his assumptions with the client the counsellor has no way of knowing if what he is feeling is correct. Therefore, instead PD may actually be protecting himself from feeling the shame-affect. When PD states that *"…it is not a big fracture if you do it properly"* (PD, L320-21) he can be referring to both the client and himself. Arguably, this example of withdrawing from therapy, and ending the sessions is also illustrative of the Amoeba Principle, because the

participant is protecting himself by firming up his boundaries through the creation of distance and space between himself and the client.

It is unclear from PD's account whether his withdrawal response is underpinned by personal or professional shame in this example. I suspect that it is personal shame because his feelings do not appear to relate to feeling incompetent in dealing with the erotic in therapy. PD approaches this from the point of view that this subject should be actively avoided at all costs which suggests a more deep-rooted element to shame, Nathanson (1992) may refer to this as PD's inherent shame.

PD was the only participant to mention counsellor/client attraction directly. However, other participants commented on the male/female dynamics in therapy evidencing an anxiety around potential attraction in therapy underpinned by shame.

Throughout her interview PC is keen to ensure the researcher knows that she does not have an issue with boundaries in her practice that is her boundary attitude. PC says *"it is not really an issue for me. Even when I had supervision, even when I was like a trainee, the boundaries issue never really came up as an issue"* (PC, L78-80). PC advises us that client/counsellor attraction is not an issue because of the ratio of female to male clients in her practice. *"But 99% of my clients have been female anyway. So that isn't an issue for me"* (PC, L87). Despite this PC has discomfort about one of her recent male clients – *"I do now have more male clients. But I haven't found it an issue except there is somebody in the last session"* (PC, L88-9). This discomfort – *"And I did feel slightly uncomfortable about it"* (PC, L91-2) - seems to be fuelled by the fact that the client is having relationship difficulties – *"who is going through some difficulties in his relationship"* (PC, L90) and that they are asking about her personal life – *"he started asking what I was doing for Christmas"* (PC, L90-1). PC appears, on

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some level, to be defensive about this question from her client. *"That is a boundary for me. I did tell him but I didn't go into any kind of detail"* (PC, L92-3). It feels as if for PC her client has crossed an unspoken boundary by requesting the details of her personal life, although PC tells the client what she is doing at Christmas she feels uncomfortable about it. It appears likely that PC tells the client because refusing to would be too embarrassing for her although even though clearly the clients question could be considered a very innocent remark at the end of a session – *"and he was like 'so what are you doing for Christmas then?' It was on the way out. It wasn't in the counselling. The counselling had ended"* (PC, L104-6).

Interestingly, PC's use of the term *"red light"* (PC, L94) suggests a fear of possible client attraction as she sees his questions as a possible warning signal. Although PC wavers in her use of this term as she struggles to find the right expression – *"not a red light"* (PC, L93-4). PC appears to protect herself from the client's queries through giving minimal detail to the client and avoiding discussing details that she was uncomfortable sharing.

PC appears to link, on some level (possibly unconsciously), the clients questioning of her own Christmas plans as a possible indicator of attraction. PC aims to avoid the shame of an interaction which may bring the clients (possible) attraction into the conscious awareness of the therapeutic relationship. Thus, protecting herself from experiencing shame. This is in effect thickening her boundaries as she distances herself from the client (emotionally). *"That is a boundary for me"* (PC, L92). The uncomfortable feelings that PC feels are slight in that she does not quite know why she feels uncomfortable and whether she needs to do anything with that feeling. This effectively avoids the issue and it is not addressed in the therapeutic relationship. Arguably, PC may be avoiding two experiences of shame: embarrassment if she

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refuses to answer the question; or embarrassment in acknowledging her uncomfortable feelings openly in the session. Either way PC has an avoidance response in this situation as detailed by the BRM.

PC questions whether the enquiry by the client is even a boundary issue – *"It is just even that I feel like, is that a boundaries issue? It is a little bit because it potentially could be"* (PC, L108-9). In this context PC is uncertain about if this is about boundaries but has uncomfortable feelings about it. This is PC's boundary experience. Her reaction is to respond with minimal information as a possible way to avoid the experience of shame. There is little feedback from the client in that they leave the session. However, PC has avoided further uncomfortable feelings by not discussing this in the session, yet has a lingering sense that something was not right with this interaction.

PB has a similar level of discomfort after she reflects about a moment of physical touch between her and a male client. *"it felt ok although I took it to supervision but still there is that thing in your head – have you crossed that boundary? Although it wasn't me who initiated it, so again very difficult, and you know female/male – that was a female/male situation, would it feel uncomfortable I always think if it was a female? Because no female has ever done that"* (PB, L30-35).

Interestingly, PB does not feel this at the initial moment of the interaction but at a later date once she has reflected about it. Furthermore, PB directs her focus on herself, as she questions whether she has crossed 'that boundary'. PB ponders over the difference between male and female touch from clients and if her response would be different for each. However, PB has nothing to compare it to and so struggles to conclude if indeed a boundary has been crossed. PB indicates that she may be feeling

shame in response to this experience as she indicates uncomfortable feelings about the interaction and whether she has done anything wrong. Arguably, PB is wrestling with professional rather than personal shame as she questions her own practice and professionalism. A certain level of uncertainty exists as PB wrestles with the notion of where the boundary line lies. For example, PB cannot decide if it is set by her – *"it felt ok"* (PB, L30), *"have you crossed that boundary?"* (PB, L31); the client – *"although it wasn't me who initiated it"* (LPB, L33); or the profession – *"I took it to supervision"* (PB, L31). PB's response to this situation is the engagement response as she has openly addressed this in supervision and explored the possibility of what it meant. PB did not explore the issue with her client but clearly did not feel the need to after exploration in supervision. In this instance PB had uncomfortable feelings when reflecting about what happened but addressed these as soon as she could.

In Rodgers (2011) study of therapists' experience of erotic transference some of the participants found that by experiencing the erotic in the therapeutic relationship that it increased their self-awareness and therefore gave them a greater understanding of their own boundaries. However, in this study participants experiencing the erotic (or perceived eroticism) appeared only to raise their fears and anxieties surrounding boundaries rather than develop them.

Mann (2015) cites favoured theories, fellow colleagues and their own 'world view' as areas that therapists instinctively wish to protect; but argues that greater rewards can be had if we "shed light on what is really there" (p144). Mann is specifically referring to the erotic in therapy, particularly issues of transference and countertransference, the concept of 'turning a blind eye' and keeping the status quo feels synonymous with the avoidance or withdrawal response from participants. It is imperative to uphold our values and ensure we cause our clients no harm, Adams (2014) argues "we can only

do this through recognition of our own weaknesses and a willingness to understand how we might be tempted into positions of false omnipotence, moral superiority and boundary violations" (p6). 'Turning a blind eye' suggests that the person knows about the issue on some level (whether that be consciously or unconsciously). They metaphorically 'turn away' from it, letting 'it be' knowing that this may not be the most appropriate response in an attempt to keep the status quo and avoid disruption. Similarly, participants 'turned away', avoided or withdrew away from certain boundary issues, such as the erotic, in their practice. This was underpinned by the participants own uncomfortable feelings, such as shame and fear.

<u>Charging Clients for Therapy</u>

Another particularly good example of a boundary issue which caused multiple responses in participants is that of charging clients for counselling sessions. It is discussed in detail by three participants - C, D and F and shows various aspects of the BRM.

Gray (1994) highlights how varying the therapeutic frame by altering terms of payment with clients should indicate to the therapist a need to consider the feelings that have been aroused about themselves and their clients. Henderson (2006) argues that therapists can feel shame surrounding charging fees for a variety of reasons, such as client neediness or because the therapist found work with that client particularly rewarding. Kearns (2011) argues that the therapy profession experiences collective shame about charging clients. Kearns argues that this is the result of a welfare state and free NHS services but also because the profession does not take itself seriously.

Some participants felt ashamed when they had to charge clients for their session. Participants had varying reasons why they felt shameful about charging clients. PF felt potentially shamed from God for charging for her services. In contrast, PC had a

general sense of embarrassment about asking for missed payments. Conversely, PD's felt that charging for his services was nothing to be ashamed of. Each example will be discussed in turn and each response will be placed upon the BRM with reasons given.

PC works in private practice, and charges for her sessions with clients. PC asks for 24 hours notice if a client cannot attend the session. However, PC finds the idea of asking for payment from a client when they have not attended a session extremely uncomfortable.

"It is hard the issue of money. I feel a bit [un]easy in asking them to pay for a session they didn't have. But I do encourage ... I do say 'I would really appreciate 24 hours notice' and most people do really. I think there are a couple of people who haven't. And one occasion my client just gave me the money, but I didn't ask her for it. I don't think I would have been able to actually ask her for the money for the missed session. So that is like a boundary issue. It could be. I find that a bit of a challenge for me."

(PC, L257-8)

In this example, PC is sharing an experience of shame as defined by Lewis (2003). PC has the wish to: hide from the client with regard to this issue ("*I don't think I would have been able to actually ask her for the money for the missed sessions*" PC, L257-8); has feelings of discomfort (*"I feel a bit [un]easy in asking them for a session they didn't have"* PC, L257*);* has feelings of unworthiness regarding the value of her time as she feels uncomfortable charging for missed sessions. Arguably, PC would feel the object of shame (i.e. felt herself to be the person who shamefully asked for payment) in addition to the subject of shame (the person who experienced shame for requesting the payment).

The challenge for PC appears to be her uncomfortable feelings about asking for payment, the interview does not explore these feelings. However, it is easy to suggest potential reasons for this e.g. fear of a negative reaction from the client, fear of judgement about the participants motivations being monetarily based etc. PC does

identify that this particular issue is about control, and links this to boundaries. *""I suppose the reason that it came to mind as a boundary is I suppose it is about ... a little bit about control as well and control is very much about boundaries. At the end of the day it is my job and my income"* (PC, L279-82).

Interestingly, what PC is talking about is a lack of control surrounding collection of payment from her clients. PC relies on this money for her income. Even if the client does not turn up for a session PC will be unable to use that time for another client. PC reacts to the shameful feelings of asking for payment for missed sessions through avoidance. PC is unable to ask for the money for the missed payment because she does not want to feel the shame-affect. PC lacks confidence in charging her clients for missed payments. Therefore, she avoids this issue completely, and admits that she could never actually ask for it. PC sits back and hopes that clients would willingly offer some money for the session effectively avoiding/evading the issue.

In another example, PF describes how her original motivation for training to be a counsellor made it difficult for her to initially charge her clients. *"Yes, because I hadn't started it in the first place that I was going to … For that reason, that I was going to be paid for it, you know what I mean, it was, I started it because of what I was doing in the Church, of listening to people"* (PF, L220-4)

Again, PF is describing shame as described by Lewis (2003). PF did not want to be seen as charging for her sessions, and felt uncomfortable about it. Initially, PF felt unworthy for charging for her time, until she accepted that she had completed courses which had cost her money and many years of training. PF appeared to overcome feelings of incompetence as she started to value her own knowledge and skills. Arguably, PF's experience of shame (or predicted experience) is that she would

somehow be judged by God if she took payment for client work instead of doing it voluntarily. *"…it was something about, offering the love of God, to people and the way that I could offer the love of God to people was actually listening to them"* (PF, L271-273). Therefore, becoming the object of shame rather than just experiencing it.

PF was uncomfortable with charging her clients, as if somehow it reflected badly on her. Interestingly, when PF worked in other settings she was much more comfortable to be paid for her practice as long as the payment was not coming directly from the client. *""You know, that kind of difference, I was kind of, more comfortable thinking that the people weren't paying, of course they were but …"* (PF, L203-4).

This statement is important because it underlines an important aspect of this participant's boundary management that is an avoidance of discomfort of shame within her sessions. Discomfort in this sense is the reluctance to ask clients for payment. The reason for this is PF's concern that asking for payment is somehow reflecting a monetary motivation for her counselling rather than spiritual. It is only when PF decides that she deserves payment because of the hard work and training that she has completed that she becomes comfortable in asking her clients for payment. However, it is not just about this because PF feels 'more comfortable' when she thought her clients were not paying directly to her but she still wanted to be paid and was happy to do this through the GP surgery. The difference in these two scenarios is in her own practice she is asking the client for money whereas in the GP surgery she is not. But in both examples she still receives payment. However, in one she experiences shame by asking the client for it in the other she does not.

PF's reaction to this shame-affect can be understood from the BRM. Similarly, to PC there is an element of avoidance of asking clients for payments. Nathanson (1992)

argues that the avoidance of shame is characterised by a slow movement away from that which causes the shame-affect. Interestingly, PF appears to describe her experience in the opposite direction. That is, PF starts her counselling career with the complete avoidance of payment from clients, but slowly over time PF moves closer to justifying why she should be paid, and therefore her shame-affect reduces. This is because she feels more competent in her practice. If we consider this on the BRM we can see that PF responds with avoidance at first but gradually over time she reflects on the issue of charging and has an engagement response. This is when she sees no threat to herself by charging, she feels confident and comfortable in doing so. This is openly spoken about with the client.

In contrast, PD describes how he has always been completely comfortable in asking for a payment from his clients. *"I never felt a tinge or remorse, guilt or reluctance about taking a fee because it was a service delivered"* (PD, L354-6). PD does identify that he has been flexible when asking for money but that he has no doubts that this is something he is entitled to do. *"But when I had the business working from here I chose to do it for reward. I never charged what other people charged because I chose not to"* (PD, L352-4).

PD argues that his experience of charging for sessions is completely free from the shame-affect. *"Well for me it is no different"* (PD, L350). PD does not at any point report that: he wishes to hide or disappear from discussing this topic with clients; he does not feel uncomfortable ('I never felt a tinge of remorse, guilt or reluctance'); and he feels validated in what he offers clients ('it was a service delivered'). Interestingly, PD describes how he did not charge the same amount as other counsellors, suggesting that PD charged less than the average rate. There could be many reasons for this, one of these may be a reluctance to appear to clients as money orientated,

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and thus feel shame. However, it could just as easily be reasons unrelated to the shame-affect such as a business decision to use lower fees to attract clients. PD is aware of the issue, has reflected on it and acts with confidence when following that decision through to its end. PD appears to follow Freud's (1913) view that therapists should "cast off false shame" (p131) when charging for their services. In this example PD has responded to the issue of charging clients with an engagement response. PD has his own clear values about charging clients and this reflects his level of comfort in charging clients. PD does not detail any boundary feedback from charging clients. Arguably, this is because it is something that does not worry him. PD says that *"it is no different"* (PD, L350) for him to charge suggesting a deep-rooted confidence in charging his clients (if he wishes to do so).

Confidentiality

Another good example of a boundary issue which caused multiple responses in participants is that of confidentiality. *"…a boundary in terms of breaking confidentiality"* (PG, L215-6). Research suggests that confidentiality is one of the more dominant ethical dilemmas for counsellors and therapists (e.g. Brown, 2006; Lindsay and Clarkson, 1999). Therefore, confidentiality can also be considered one of the main boundary issues. Examples of confidentiality are discussed in detail by two participants – B and G (but confidentiality is also mentioned by others (A, C and F). Confidentiality can be considered a shield to protect the client and is argued to be, out of all ethical dilemmas, the cause of most ethical anxiety for counsellors (Bond, 2015). Hudson-Allez (2004) highlights the disparity between the requirements for confidentiality in law and that of psychotherapy arguing that the law can erode the trust in the therapeutic frame and even alter the process of psychotherapy itself. The most ethical approach to confidentiality is fully informed consent for clients (Bond and

Mitchels, 2015). Discussions of confidentiality in counselling often focus on the legality or morality of breaking confidentiality (Bond, 2015; Bond and Mitchels, 2015). However, there is some limited discussion and research into how counsellors or therapists experience the issue of confidentiality in their practice which is also discussed in this section.

PG gives two examples of confidentiality in her interview. In both examples confidentiality is raised in terms of protecting the client's safety. However, in one example PG breaks confidentiality and the other she does not which is useful for discussion and understanding these different boundary responses.

In the first example PG is worried about whether to break confidentiality to ensure the client's safety after the session has ended. *"I was concerned about erm, about their kind of wellbeing over a holiday period"* (PG, L576-7). So she gives the client her phone number in case she needs to contact her in an emergency. *"…there is another one that I`m saying to you now, about a phone number"* (PG, L573-4). In this example, the boundary issue is the non-disclosure of PG's concerns about the client's safety to either her organisation or her supervisor. Therefore, PG decides to keep the confidentiality of the client (there is another boundary issue here which is giving the client her telephone number which is discussed here in terms of how it impacted on PG's decision to not break confidentiality).

As previously identified PG is concerned about her client's safety over the holiday period. PG is able to justify why she did not break confidentiality. *"I didn't feel enough to break confidentiality and part of that was because of an assurance that, that she'd given me an assurance that she'd stay safe"* (PG, L580-2). However, PG admits that she is contradicting herself - *"…I`m going to contradict myself now"* (PG, L579-80) –

because she *was* worried enough about the client to give *"her my number"* (PG, L582-3). It is understandable why PG may not have felt able to break confidentiality with her client for fear of disrupting the relationship for example.

Jenkins (2003) found therapists described a negative experience when they were forced to break confidentiality which was deeply emotional and included feelings of stress and guilt. Similarly, Reeves and Mintz (2001) found counsellors felt that they were letting their clients down or betraying them in some way. Interestingly, the therapists in Jenkins study argued that they valued client confidentiality as part of their professional ethics whilst also feeling personally violated by requests to break client confidentiality. Jenkins argues that one reason for this may be a breach of the therapists own privacy as their notes and statements about the client are shared.

Arguably then, this response by PG is underpinned by feelings of shame as she aims to avoid feelings of guilt and embarrassment if she broke the client's confidence. Arguably, PG alleviates her own guilt of 'doing nothing' by giving the client her phone number. *"She never actually contacted me, but <u>I kind of felt that</u> if she had that then, that might have just been enough, and as it, in essence she didn't harm herself though it made, part way have been enough"* (PG, L583-5). In this quote PG identifies her own feelings 'I kind of felt' but does not clarify with the client how this gesture impacted on them. PG admits that giving the client her phone number may have had no effect at all - *"I don't know, whether I`m sure that was a significant thing or not. Maybe it never was"* (PG, L585-7).

Interestingly, PG did not tell me about this issue initially. I can only assume that PG was worried about my reaction to her non-disclosure of concerns about her client and giving them her phone number she says *"that I`ve lied to you, that I have done that.*

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And I did again, look at me I`m embarrassed now"* (PG, L574-5). This suggests that PG was worried about appearing incompetent or unprofessional in front of the researcher. PG admitted *"I don't want to foster dependency"* (PG, L597). PG was also keen to let me know that she had not done this with any other clients. *"…you know I`ve never text a client and I`ve never text them, ever text them to say, you know are you ok, and there only this one client, I`ve never text them to say are you ok. And I would never ever contact them. I am very very clear about that. I`ll never ever contact them" (PG, L607-10). This was because *"there was something different, yeah, that I did feel concerned"* (PG, L606). Which suggests that it was important to PG that I know that this an unusual circumstance and not her usual practice.

PG's experiences feelings of anxiety about her client's safety. PG does not feel she needs to break confidentiality because her concerns have not reached that level. In addition, she has received reassurances from the client but still feels that this is not enough and offers the client her own telephone number. This may alleviate her own feelings of guilt of being able to do anything else and may alleviate some of her fear for the client's safety. PG has discussed her concerns with the client. PG must make a decision in that session because she does not have time to consult her supervisor or any other ethical decision-making support. This supports an argument for this to be an *engagement* response of the BRM. However, there is also an argument to be had that PG has responded, in part, with *avoidance* in this example because she does not share her concerns with others. However, as described PG is in a difficult position and risks the relationship if the client does not wish for her concerns to be shared. It appears however that PG does not discuss this possibility with the client so it is difficult to judge how they would have reacted. Furthermore, there is no indication that PG discusses this issue in supervision after it has occurred. This suggests to me two

potential aspects of shame here. Firstly, PG may not have approached the subject of breaking confidentiality for fear of being embarrassed in front of the client if they do not like this suggestion. Secondly, PG has not discussed the issue in retrospect with her supervisor for fear that she will be judged for giving out her phone number (this argument is supported by PG's fear of disclosure to the researcher). I would suggest that there is an element of avoidance in PG's response here because of her lack of openness with others about her response to this boundary issue. This is supported when we consider PG's second example where she *does* break confidentiality for safeguarding reasons and is also open about it with others.

In the second example PG has concerns about her client's welfare and reports this. *"I know the other thing that we did together, but college were aware of this. Is that once we were, when I broke confidentiality about her kind of potential harm to herself"* (PG, L195-7). Due to PG's concerns, she accompanies her client to a medical appointment *"…the welfare officer here, was kind of keen for her to kind of, to see a doctor. With the possibility of medication, and she didn't want her Mum to be involved"* (PG, L197-9). In this example, PG does not break the client's confidence by reporting any concerns to her mother. However, she does feel the need to inform the college. *"But college were aware of that. So that was kind of recorded and that was monitored, and we kind of made the appointment"* (PG, L207-10). In this example, PG seems to suggest that the recording and monitoring of this was important and that this was a decision made with the college. *"…so with the permission of college … It's kind of agreed that I would accompany her to the doctor"* (PG, L201-3). This example contrasts significantly with the first in the level of transparency and openness with which this decision is made. There appears to be no element of avoidance here. Circumstances are clearly different – the first is an immediate decision which has to

be made in the context of that moment whereas the second example is planned and thought through. However, by applying the BRM to both brings new insights to both these examples of practice.

PB acknowledges the importance of confidentiality and discusses an example or working in a multi-disciplinary team. For PB the multi-disciplinary team was too open with their discussions of clients and was therefore breaking confidentiality. *"[a client] could be coming through that door, doing different various therapies psychology, psychiatry, child protection services, they're all in there, discussing all different things, and it's very easy to just run away with your chat"* (PB, L670-3). PB has uncomfortable feelings about this and responds in various different ways. PB has an *attack-other* response as she expresses her anger at the other professionals. *"I`d be like "stop that, stop that now", you know"* (PB, L663-4). PB also had a *withdrawal* response as she removes herself from the situation so she could not hear the discussions of clients. *"So, I did used to spend a lot more time with a book in the counselling room by myself"* (PB, L675-6). This does not solve the problem but it does enable PB to protect herself from hearing these discussions. However, all this is not enough for PG and so she ends up having a *challenge* response as she aims to put a stop to the breaking of confidentiality with other professionals by discussing it with the manager. *"I said to the organisers, the manager there, said I knew him, and at some points I would leave or go in the other counselling room, erm, when we chatted about clients, you know, and he said I never thought about that, so he had never thought about it"* (PB, L664-7). Which resulted in further reflection from the manager as he said - *"…"so that is something that is needed, because actually … we need to think about that one""* (PB, L668-9).

Summary

The chapter has detailed the BRM which is a representation of how the participants' understanding and experience boundaries in their practice with a focus on how they respond to boundary issues. It acknowledges the idiosyncratic nature of boundaries as identified by participants. It acknowledges that boundary issues are context specific when they are experienced and allows for this. The BRM is split into 8 distinct responses identified within the participants' accounts. Each response is characterised by various elements although there may be some overlap between them. The BRM highlights how the predominant purpose of boundaries within counselling is that of protection. This can be protection of the client or of the counsellor. However, participants gave more examples of how boundaries protected themselves rather than their clients. Participants indicated that their self-protection was a priority before they could then focus their attention on the client.

The predominant (although not the only) response towards boundary issues was one of self-protection for the counsellor and this is relayed in the BRM. Feelings of fear, shame and incompetence were evident throughout participants' experience of boundaries although the majority of these were covert rather than overt references. Participants' experiences were defined as shame using Nathanson's (1992) broad definition which includes experiences of shyness, guilt, embarrassment or humiliation. This enabled the BRM to include a wider variety of participants' experiences. Participants protected themselves from potential threats. These threats could be physical in nature such as the threat of violence or a complaint. However, they could also be feelings that the counsellor was trying to avoid such as fear, shame and feelings of incompetence. Participants aimed to protect themselves from these feelings because each experience impacted on their sense of self. Experiences of

shame often turn the focus on 'self' rather than on 'other' (Kearns, 2006). Shame will therefore impact negatively on a counsellor's empathic ability and their ability to respond appropriately to clients. Arguably this is also true of fear and feeling of incompetence. These are examples of the Amoeba Principle in action because there is what can be called a 'thickening' of boundaries which happens as the counsellor becomes more focused in on themselves and not on the client. The BRM aims to represent these participants' defensive reaction to feelings of fear, shame and incompetence.

The Amoeba Principle (Hartmann, 2011), Triangle of Conflict (Malan, 2007) and the Compass of Shame models (Nathanson, 1992) have influenced the analysis of the participants' accounts and in mapping out how they respond to boundary issues. However, they were not able to offer a full picture of the participants' responses and therefore a new model was proposed. The Boundary Response Model (BRM) proposes eight distinct boundary responses. This has resulted in a model which, once validated, could be used by counsellors (or supervisors or trainers) to explore counsellors' response to boundary issues in their practice.

Practical applications

This model can be useful for counsellors in practice, training and supervisory sessions because it enables the counsellor or supervisor to ask some specific questions about the counsellor's attitude to and response to specific boundary issues. The model does not specify what those boundary issues are or in what context that they occur, it only asks the counsellor to explore how they respond to them. It ensures that any counsellor can use this model irrelevant of how they define boundaries or indeed boundary issues. It enables counsellors to explore where their response exists within the proposed model and reflect on whether they feel that they should be somewhere

else on the model. It enables the counsellor to reflect on what they can do to respond differently to the specific boundary issue in the future. In this respect, it gives the counsellor questions to ask about specific areas of their practice and an opportunity to explore these. To support in the application of this model as a tool for training, development and supervision a set of exploratory questions have been devised to help counsellors identify where their boundary responses lie on the BRM with regards to specific issues. These are detailed in the discussion section in chapter seven which is detailed next.

Chapter Seven: Discussion

This chapter aims to compare counsellor participants' understanding and experience of boundaries with the current literature on boundaries. The following chapter discusses some of the issues raised within this thesis in more detail and places the findings from the last chapters in the broader context of the profession and current literature.

It was argued earlier that the counselling profession in the UK may be moving towards what could be considered a 'post-modern' position (House & Musgrave, 2013; Ross, 2010). That is a profession which aims to surpass the limitations of the traditional therapeutic modalities and moves towards a more multi-modality approach (House and Musgrave, 2013; Parker, 1999). Parker (1999) states "by positioning postmodernism as a metaphorical transitional boundary, we can see it as a site for critically rethinking therapy discourse, rather than as an obligation to take sides and declare allegiances" (p72). Arguably, the evidence of this move is found in the momentum with which the pluralistic approach to therapy has gathered influence in the UK (Carey, 2016; Cooper, 2016; Cooper and Dryden, 2016; Cooper & McLeod, 2012; Gabriel, 2016a; Thompson & Cooper, 2012). However, some have questioned how inclusive and committed this approach is to a truly pluralistic perspective when it consists mainly of therapists who are from one tradition i.e. the humanistic-existential tradition (Dryden, 2012; Ross, 2012). In addition, the profession is moving away from discussing counselling and therapy in purely theoretical terms to a much more evidence and research based endeavour (BACP, 2013b; Cooper, 2008). Arguably, the notion of boundaries in counselling has yet to fully follow this path. Certainly, the pluralistic approach to therapy has put forward an approach to boundaries which could

be 'post-modern' because it is not tied to any of the traditional therapies and focuses much more on the outcomes for the client (Carey, 2016). Perhaps surprisingly, given the focus on evidenced based practice, this proposal is not clearly based on practitioner based research but theoretical discussion. Research on the influence of boundaries on therapeutic outcomes is also limited (Cooper, 2008). Furthermore, the pluralistic approach to boundaries cannot be considered fully post-modern in its approach because it still argues against using boundaries to limit or restrict in therapy (Carey, 2016). This thesis argues that the concept of 'boundary' needs to be considered from a post-modern perspective. It is a concept that is extremely complex and multi-faceted that transcends beyond just the therapeutic modality of the counsellor and works at multiple levels during counselling practice. This is evidenced in the participants of this study who have detailed an idiosyncratic understanding and approach towards boundaries which often differs to their experience of boundary issues.

Postmodern thinking is useful in that it challenges us to think about the limitations of narrow modalities yet is useless if it argues that it makes no differences at all what modality is being used because this would be an 'anything goes' approach (Howard, 2000) which lacks any form of accountability. Arguably then, the field requires an approach which can hold the tensions between the need to ensure the accountability of its counsellors whilst keeping the diversity of approaches from which they practice (House & Musgrave, 2013). If, as this thesis argues, a counsellor's understanding of boundaries is idiosyncratic then they not only need to be accountable for how they use them (including their responses to boundary issues); but they also need training and support to develop a greater awareness of how they impact on their practice.

This thesis supports the notion that the concept of 'boundary' is too complex and multifaceted to be defined in one singular definition (Gutheil and Gabbard, 1993). Although there were similarities in the participants' definitions of boundary each one had its own particular focus. There were broad similarities with participants' definitions and those that exist within the counselling, psychotherapy and associated literature (Bond, 2015; Davies, 2007; Feltham, 2010; Gutheil and Brodsky, 2008; Proctor, 2014; Sakar, 2004 and Zur, 2010). However, participants placed their own emphasis on their definitions which meant they could not be considered directly comparable to the definitions within the literature. **Therefore, this thesis suggests that a counsellor's understanding of the concept of 'boundary' is unique.** This has clear implications for counselling practice. If counsellors define the concept of boundary in their own unique way then discussions with colleagues, tutors or supervisors can be misconstrued as individuals may be discussing very different concepts. This issue may cause even more profound difficulties if discussions around boundaries are held with clients because they are even less likely to understand the term.

To address this issue, I suggest that rather than make assumptions about how counsellors define boundaries supervisors and tutors should be actively exploring the concept of boundary with their supervisees and students to create a deeper awareness of how counsellors understand the concept. This would enable a more open conversation and lead to greater awareness for counsellors surrounding boundaries. Arguably, if counsellors, supervisors and tutors could acknowledge that each person defines boundaries very differently and have open conversations about this then this may result in a reduction of shameful experiences surrounding boundary issues as miscommunication and confusion is decreased. The counselling literature argues that counsellors need to be offering clear and transparent boundaries to clients

to enable a successful therapeutic encounter for clients (Owens, Springwood and Wilson, 2012; Reeves, 2015). However, this is clearly difficult to achieve when counsellors define the very meaning of 'boundary' very differently.

If, as Gutheil and Gabbard (1993) suggest that the concept is too difficult to define singularly - a claim that is supported by the participants' responses in this study - then the question might be raised regarding its usefulness as a concept in counselling. This is then surely further complicated when reviewing the increased prevalence of the concept within the counselling literature (e.g. BACP, 2016a); the volume of material surely suggesting that as a concept, 'boundaries' is of import to counselling practice. Indeed, despite defining boundaries in their own unique way all the counsellors in this study identified boundaries as imperative and integral to their counselling practice. Thus, it can be argued that the concept of boundary _is_ useful for counsellors despite their understanding of it being unique.

If the concept of 'boundary' is unclearly defined within the literature then the concept of 'boundary issue' is even more unclear. The use of the term 'boundary issue' is not as dominant as that of 'boundary'. However, it is used in: introductory texts (McLeod, 2013); discussions on ethics (e.g. Proctor, 2014) and the literature provided to counselling clients (e.g. BACP Register of Counsellors and Psychotherapists, 2016). It most commonly appears to refer to ethical dilemmas or an issue that causes conflict or concern (Reamer, 2001). Bond defines 'issues' as "[s]ignificant problems or topics that require a decision or action to resolve them" (2015, p307). However, similarly to the term 'boundary' the concept of 'boundary issue' is often left undefined when used in the literature (e.g. Proctor, 2014; Reeves, 2013). This thesis did not originally set out to define the concept of 'boundary issue'; its usefulness as a concept did not come to the fore until after the analysis of the research findings (and therefore it did not form

part of the research questions for participants). However, this thesis argues it is important to clearly define this term because it represents an important aspect of the boundary decision making process for counsellors. **Therefore, this thesis proposes that the concept of 'boundary issue' is defined as *any* aspect of counselling that impacts on the therapeutic encounter.** Rather than become more specific with terms this thesis argues that a broader terminology should be used when discussing boundary issues to ensure it encompasses all types of issue and not just those that are ethical in nature. This is an argument that has already been made by other authors but is not only reinforced here through this thesis but the usefulness of using such a definition is also made clear. The proposed definition purposefully covers a very broad remit. This term is neutral rather than deemed positive or negative (i.e. it does not have any particular connotation) such as the negative connotation of the term 'violation' (Adshead, 2012; Glass, 2003). The term is also neutral because it does not necessarily indicate that there is a problem or dilemma associated with it. Therefore, it can be used to discuss any aspects of counselling that impacts the therapeutic encounter.

This thesis proposes that counsellors have their own approach towards the application of boundaries in counselling sessions – this has been labelled their 'boundary attitude'. The counsellor's boundary attitude consists of their understanding of the term 'boundary' whilst also including their thoughts, feelings and views on the application of boundaries in counselling. This does not necessarily correlate to exactly how they use it in counselling sessions but gives an indication of their basic stance. This is further informed by any experience of boundary issues within their practice. This thesis found that the boundary attitude of the counsellor does not necessarily correlate with the practitioner's therapeutic tradition. It was instead more heavily influenced by the

counsellor's own values and beliefs. This is an important finding of this study. It supports the notion that a counsellor's practice can often be characterised in an unrealistic stereotype if it is only viewed through the eyes of the modality they were trained in (Feltham, 2010). This was clearly evidenced by one of the person-centred participants (PA) who advocated the use of boundaries to construct a rigid framework in which to deliver her counselling practice. This style went against the stereotype of the modality she was trained in the person-centred approach (Mearns and Thorne, 2013) and drew comparisons with the psychodynamic tradition and the use of the therapeutic frame as a tool (Symons and Wheeler, 2005; Gray, 1994; Jacobs, 2010).

There are other influences apart from the values and beliefs of the counsellor. For example, the Boundary Process Model supports evidence that a therapist's boundary attitude may (over time) be influenced by their professional identity (Ronnestad & Skovholt, 2003; Skovholt & Ronnestad, 1995). This is because despite participants identifying their own values and beliefs as key in their attitude toward boundaries, over time the boundary feedback that they receive when responding to boundary issues will feed into their boundary attitude. It is easy to see how this feedback could also be incorporated into a therapist's professional identity for example when they have positive or negative feedback from their responses. Despite these other influences the values and beliefs of the counsellor are the most central.

This thesis argues that although a counsellor's modality may influence a counsellor's boundary attitude it is but one influence in a field of many. The biggest influence to the counsellors' boundary attitude was their own values and beliefs.

Discussion about boundaries in the counselling literature can often focus around the debate between the application of rigid versus flexible boundaries in counselling (e.g. Carey, 2016; Jacob, 2010; Mearns and Thorne, 2013; Proctor, 2014; Reeves, 2015). However, detailed discussions from practitioners about their own use of boundaries indicates that counsellors often have their own unique approach to boundaries which goes beyond the rigid versus flexible argument (e.g. Cobb, 2010; Devereux and Coe, 2010; Ingham, 2010; Priestly, 2010; Ryan, 2010; Solomon, 2010). The participants of this study all had multiple approaches to boundaries (i.e. they cannot just be pigeon holed into a box labelled 'rigid' or one labelled 'flexible'). Certainly, through an overview of the participants' accounts it is possible to characterise each account under one of these headings. However, by doing so risks oversimplifying the participants' accounts. Labelling a participant as 'rigid' in their use of boundaries, for example, could mean overlooking instances when they have been flexible or vice versa.

This thesis proposes a set of Boundary Attitude Questions (as detailed below). These questions are based on counsellors understanding of and attitude towards boundaries in their practice. These questions aim to focus the counsellor on how they define and approach boundaries in their practice to help raise their awareness and also as a starting point for further discussion in supervision or training.

<u>**Boundary Attitude Questions**</u>

<u>Understanding</u>

What is a boundary?

What is a boundary in counselling practice?

<u>Attitude</u>

What does the term boundary mean to you? (Think of feelings, images and experiences that it reminds you of both inside and outside of counselling)

How important are boundaries for your counselling practice?

How often do you use them? Can you give examples?

How often do you discuss them with your clients?

Do you use the actual word 'boundary' with clients? Why do you choose to do this?

How often do you discuss boundaries in supervision?

Do you use the actual word 'boundary' in supervision? Why do you choose to do this?

What do you use boundaries for? Can you give examples?

Do you use boundaries in your personal life? If so how important are they to you?

Questions 1: Boundary Attitude Questions

Hartmann (1997; 2011) argues that boundaries are an aspect of our personality with relatively 'thickness' or 'thinness' associated with different personality traits. Overall thin boundaries are said to indicate openness, trust, vulnerability and a 'rich fantasy life' whereas overall thick boundaries is said to indicate solid, well-organised and rigid characteristics. This thesis would not support the argument that boundaries are in some way part of our personality. Although participants in this study indicated an idiosyncratic understanding and approach to boundaries they also heavily indicated that contextual and situational factors are also very important when applying boundaries. The Boundary Questionnaire detailed by Hartmann has predetermined questions to score which do not allow any space for contextual or situational details which may influence a person's answer. Similarly, the Boundary Attitude Questions do not allow for situational or contextual aspects to be considered because they are looking at a counsellor's general approach to boundaries.

This thesis has created a Boundary Response Model (BRM) which represents how counsellors respond to boundary issues which includes the role of context.

Most of the decision making models in counselling are based on ethical decision making (e.g. Bond, 2015; Gabriel, 2016a; Pope and Vasquez; Proctor, 2014). With the

exception of Carey's (2016) decision making guide in pluralistic counselling which is based on a 'flexible and responsive application of therapeutic boundaries' (p349). These models focus on supporting counsellors through the process to make ethical or boundary decisions by incorporating various aspects of practice and critically analysing each part to come to a specific conclusion. These models assume that counsellors are consciously and critically reflecting upon their practice. However, this research suggests that counsellors often use instinctive rather than critical and reflective responses to boundary issues. Furthermore, many of these decisions can be guided by unconscious feelings of shame or have become standard responses which have become comfortable for the counsellor over time. Although many of the current models argue for the counsellor or therapist to examine their own bias or agenda there is often not enough detail for counsellors to consider how to do this. As this thesis has previously argued trainee and practicing counsellors need to be challenged to re-examine how they respond to boundary issues, their experiences of shame and whether this has developed into defensive practice. The BRM (and supporting Boundary Issue Questions) is the first tool to support counsellors with boundary related decisions which is based in the experience of qualified and practicing counsellors.

Therefore, this thesis proposes the Boundary Issue Questions (detailed below) can be used as a further tool by counsellors to consider their responses to specific boundary issues and the particular context they occurred in.

As previously stated this thesis did not set out to explore how counsellors respond to boundary issues. However, this thesis found that participants could articulate these experiences much more easily than trying to define boundaries or their use of them. There are a variety of possible reasons for this. Participants were anxious about

answering direct questions about boundaries. Some participants were keen to give the 'right' answer or one that fitted in with other participants (some actually asked for the other participants' answers). This may be further evidence of the shame affect as the participants may have been frightened to appear incompetent or embarrassed by giving a wrong answer. Whereas others had never really thought about defining boundaries before. However, despite this apprehension participants knew the term 'boundary' and deemed it useful to their practice. In contrast, participants were much more able to articulate their answers when discussing boundary issues and describing how they *responded* to them despite not being asked directly about them. This makes sense when considering that a similar process would be followed in supervision – counsellors talking about their experiences of counselling sessions – something these counsellors would be used to. Furthermore, by broadening the definition of 'boundary issue' this thesis has captured a much broader array of responses than if it had just looked at problems or dilemmas in the counsellors practice.

Boundary Issue Questions

What is the boundary issue that you are concerned about/would like to explore?

How do you feel about the presenting issue?

What was the context this issue occurred in? (What was the venue? Time of day? Was the client male or female? What rules dictate your response? E.g. are you in private practice or an organisation? What impact did this have on your feelings about this issue?)

Does it make you feel comfortable or uncomfortable? Why?

Do you feel anxious about dealing with this issue? Why?

Are you fearful of this issue? Are you fearful of the client? Why?

Do you feel confident or lack confidence in dealing with this issue? Why? Have you experience of working with this issue before? If so, what was the outcome? Have you reflected on this experience? If not why not? If you have reflected on it did it change your response to this type of issue? If so why?

Do you feel like you want to approach and tackle the issue or hide away from it? Do you feel the need to do this immediately or expect the issue to fade away over time?

Are you anxious about feeling embarrassed if you deal with this issue incorrectly?

Were you embarrassed by how you dealt with this issue in a counselling session? If so what did you do about it?

Do you feel the need to protect yourself from this issue? Or from your client?

Have you decided to withdraw from this issue? From an aspect of the therapy? The client? Or the therapy itself? If so, why?

Do you have feelings of anger? Are these directed at the client?

Do you acknowledge that there is an issue to deal with?

Have you tried to engage with this issue? If so, how?

Have you felt the need to challenge the client in a session? If so, why? Was this a conscious and planned challenge or was it an unconscious and reactionary challenge?

Are you fearful of challenging the client? If so, why?

When responding to the boundary issue did you feel that you were still emotionally available to the client? And able to offer empathy and listen effectively? If not, why?

Are you anxious about discussing this issue in supervision?

Questions 2: Boundary Issue Questions

The counselling literature can often challenge the usefulness of the boundary concept or aspects of it because of its association with the idea of restriction and defence plus its role in defining the limits of something (e.g. Carey, 2016; Mearns and Thorne, 2013; Totton, 2010). These terms do not always easily fit in with a profession that is often argued to be based on three core concepts: empathy, congruence and unconditional positive regard (McLeod, 2013). As PE put it *"I am thinking of… a fence that's how I'm thinking of it …but that doesn't necessarily, that's not quite so easy to fit in with counselling"* (PE, L34-5). Alternative terms have been proposed to replace the term in all helping professions such as territory, highway and bridge (Austin, Bergum, Nuttgens, Peternelj-Taylor, 2006). However, these alternative terms have often failed to pick up popularity within the field of counselling or elsewhere. In many ways, the fundamental elements of the concept of 'boundary' have changed little since its very

early first uses from the Anglo-Latin word 'bunda' meaning 'limit' (Harper, 2017). Participants of this study used boundaries to limit, restrict and defend many different aspects of their practice including defence of the self. This reminds me of the medieval words used in the development of the boundary concept that define the limits of an area of land (Harper, 2017). Counsellors in this study effectively described using boundaries in this way by defining their own 'area of land' (i.e. their own therapeutic space) which was effectively their own approach to practice. Carey (2016) argues that boundaries should not be used to limit or restrict in any way in counselling. However, participants in this study suggest that that is exactly how they use this concept – to restrict, limit and defend! Certainly, many of the issues raised in this thesis ask questions about the appropriateness of using the concept in this way without questioning and reflecting on such an approach. Particularly if this approach is not in the client's interest. However, if the concept of 'boundary' is to continue its dominance within the field then the profession needs to acknowledge that using boundaries to restrict and limit in sessions can have a positive as well as negative effect on clients. Furthermore, it can be imperative for the safety and security of the counsellor!

This thesis supports the argument that the discussion of boundaries needs to go beyond that of professional ethics otherwise it risks limiting the discussion to the minimum standards of practice (Bond, 2008). Participants in this study identified an ethical aspect towards their understanding and approach to boundaries however their experience and response to boundary issues often referred to much more. This thesis argues that there are a variety of ways that the profession can support a much broader discussion of boundaries in the literature and in training courses and supervisory relationships. For example, the terminology used to discuss boundaries is important. As discussed, this thesis recommends that the term 'boundary issue' should be used

to refer to any aspect of counselling that impacts on the therapeutic encounter. The current terminology of 'crossing', 'transgression' or 'violation' can be unhelpful particularly when it may inadvertently discourage detailed discussions about variations in practice. In turn terms like violation are likely to lead to counsellors potentially experiencing higher levels of shame when varying their practice.

Another way to broaden the discussion of boundaries beyond the area of ethics is to consider practical and meaningful ways that counsellors can engage in safe exploration of this issue in their practice. The boundary concept is becoming ingrained within the ethical codes and frameworks in the UK (BACP, 2016a; UKCP, 2009). Some participants referred to ethical codes when discussing boundaries. However, this was often a fleeting reference which did not appear to have any meaningful relationship to the responses that they made surrounding boundary issues. There are models for ethical decision making which aim to support counsellors in making specific ethical decisions or dilemmas in their practice (e.g. Bond, 2015; Gabriel, 2016b; Pope and Vasquez, 2016). However, the participant accounts suggested that there were numerous other opportunities when counsellors may benefit from support in making boundary related decisions rather than just ethical dilemmas such as the decision of whether to charge their clients or the way they set up their counselling room. Gabriel (2005) argues for an integration of intuition into decision making and psychological processes for counsellors and therapists. Certainly, many of these models incorporate aspects of reflective practice as part of ethical decision making (e.g. Gabriel, 2016b; Pope and Vasquez, 2016). However, the boundary process model is unique in that it enables counsellors to consider the process through which they respond to boundary issues and the impact that each experience has on how they respond in the future. This model is based in counsellors understanding and experience of boundaries rather

than from a top down perspective so in this respect it fills a gap within the research literature. Due to the small number of participants in this study it clearly cannot be generalised across all counsellors. However, it can be used to support discussions with counsellors about their boundary process.

The profession has made some attempts to create meaningful ways for counsellors to engage with boundary issues. For example, the pluralistic model of boundaries proposes various pragmatic questions that can be used to guide the practitioner through the preparation, planning, monitoring and reviewing of applying therapeutic boundaries (Carey, 2016). Gabriel (2016) aims to support counsellors in their ethical decision-making process by proposing various questions that counsellors can ask themselves which includes checking the personal impact of any decisions. These questions are a result of drawing together a variety of ethical decision-making models into an easily understandable and pragmatic tool for counsellors. As detailed earlier this research proposes two sets of questions which can support counsellors in how they approach boundaries in their practice (Boundary Attitude Questions) and how they respond to specific boundary issues (Boundary Issue Questions). These two sets of questions have similarities to Carey (2016) and Gabriel's (2016) questions. However, I would argue that they not only look at some of these specific issues in more detail through the questions asked but they are based from the actual understanding and experience of qualified and practicing counsellors and are therefore likely to be more meaningful to counselling practice. Furthermore, decision making models are not useful for the counsellor if they are unaware of the problem, or useful in supervision if the counsellor does not disclose it to their supervisor (Sweeney and Creaner, 2014). Therefore, the Boundary Issue Questions can be used as an

exploratory tool for counsellors individually or in supervision rather than just a tool to make specific decisions.

The avoidance of exploitation and abuse is an important aspect of the boundary concept. This is highlighted in the ethical frameworks (BACP, 2016a; COSCA, 2014; UKCP, 2009) and counselling literature (e.g. Bond, 2015; Kent, 2013; Proctor, 2014). Participants in this study were extremely clear on the role of boundaries in protecting clients from exploitation and abuse. Participants could identify how the role of boundary was to 'restrain' and 'restrict' the counsellor from 'crossing the line' and ensuring that the client was safe. However, the participants were also very clear that for them the role of boundary was ultimately about self-protection.

This often meant that participants used boundaries to protect themselves when faced with a threat to themselves either personally or professionally. The types of threat to the counsellor varied greatly. However, they were often underpinned by feelings of shame or fear.

Participants identified both their personal and their professional shame as an influence on their management of boundaries. Participants shared feelings of shame which echoed Nathanson's (1992) dual classification of shame that is innate feelings of shame and social shame learnt through social interactions. Innate shame related to the participants own personal experiences outside of therapy. For example, PC identified the impact of her religious beliefs on her experience of shame and boundaries, whereas PD identified the influence of an old boss on his understanding of right and wrong (these examples are explored in much more detail in other sections of this thesis).

Social shame related to the participants feelings around being judged as a professional counsellor or therapist. For example, PB identified about her fear of judgement from her peers, and PD talked about the judgement of an official investigation and inquiry.

Henderson (2006) argues that psychotherapists (Henderson refers to analytical psychotherapist but one assumes that he refers to all psychotherapists) experience shame on both the affective and social level, but adds a third dimension, arguing that they also experience it epistemologically. That is an experience of shame which impacts on the therapist's sense of knowledge. The extent of participants' experience of shame throughout the interviews suggests that these counsellors also experience shame at this deeper level as it greatly influenced their practice, particularly surrounding boundaries. This similarity existed despite the obvious differences in training and experience between counsellors and analytical psychotherapists.

Henderson (2006) also argues that there is an inherent shame in being a psychotherapist and that part of a developing a "secure therapeutic identity" (p327) for therapists means living with this shame. Barnett's (2007) small study found shame to be a key aspect of psychotherapist histories and found early experiences of shame may result in patterns of self-sacrificing behaviour in therapy. For Barnett, it is these patterns which can result in the therapist aiming for clients to see them as "idealized parental figures" (p267). Barnett suggests that this can lead to therapists overvaluing themselves and focusing all that is bad towards the client. Whereas Epstein (1994) argues that therapists who create maladaptive defences against shame can often be narcissistic and can therefore often play a role in boundary violations.

It is unclear if participants of this study had shame as a key aspect of their personal histories as this was largely unexplored within the interviews. Shame did play a part in participants' professional histories. This could often result in a defensive reaction from the counsellor. Adams states "[s]hame and defensiveness are … symptoms, warning signs that something needs to be considered, even while there is a powerful drive to keep it to ourselves" (2014, p114). Shame is also already acknowledged as inhibitor to good practice for therapists because it can lead the therapist to cross ethical boundaries, give in to impulse or overexert their power (Adams, 2014). However, in some respects a defensive reaction may be appropriate, for example responding to a threat of physical violence from a client. However, defensive reactions can also result in defensive practice. This can be a risk to the client through neglectful or careless practice (Proctor, 2014). None of the participants in this study detailed practice I would consider neglectful (i.e. harmful to the client). However, there were boundary issues which participants avoided either consciously or unconsciously to protect themselves from shame. Adams (2014) states that during these type of events, therapists are attempting to get relief from their anxiety over the short term whilst risking the vulnerability of their clients over the long term.

Counsellors 'defences' are raised when experiencing shame or the potential for experiencing shame becomes evident. This results in a 'thickening' of boundaries in line with the Amoeba Principle as set out by Hartmann (2011). Webb (1997) identifies the detrimental impact that shame can have on exploring boundary problems for counsellors. If a culture of shame festers (particularly on training programs) then this can result in boundary issues being forced away from discussion and the counsellors own awareness. Therefore, training courses should focus on area of therapy that may be more likely to result in experiences of shame. For example, Bond (2015) argues

that counsellor training courses need a greater focus on how to handle uncomfortable feelings of sexual attraction to clients; and Tudor (1998) argues that discussions of money in counselling should be open and transparent both on training courses and in therapy sessions with clients so that the subject does not become "the taboo of filthy lucre" (p491).

Participants did not consciously identify feelings of shame within their accounts. That is, they did not specifically identify feelings of shame when experiencing boundary issues. However, each participant did detail emotional reactions which could be labelled as shame when considered through the broad definition given by Nathanson (1992) which includes all aspects of guilt, humiliation and embarrassment. Shame is often conceptualised as an intrapsychic phenomenon however shame can also be considered in the context of a person's societal or cultural placement (Leeming and Boyle, 2004). Therefore, counsellors can experience their own personal shame (as a result of their own values and beliefs), professional shame (as a result of their own or others professional values) or situational shame (as a result of their specific interaction with a client). Counsellors' feelings of shame were characterised by further feelings of uncomfortableness, anxiety and incompetence. This emotional reaction often underpinned defensive responses to boundary issues.

Totton (2010) suggests that the boundary concept was taken from the work of survivors of sexual abuse and although useful in that context has (unjustifiably) reaffirmed the idea of the 'slippery slope' argument. That is the notion that any breaking of boundaries leads counsellors down a 'slippery slope' towards more harmful boundary abuses towards clients. Totton also questions the very notion of therapeutic boundaries or the 'therapeutic frame' as an integral aspect to every type

of therapy. He argues that the very notion has resulted in defensive practice from counsellors as they have unquestioningly built it into their practice. In favour of a more open encounter between counsellor and client, Totton states "[f]or a therapist to hold careful boundaries because they believe they must, or because they are afraid of the uncontrollability of closeness, cripples the potential for relatedness" (Totton, 2010). This thesis supports Totton's argument that the boundary concept reinforces defensive practice with counsellors. However rather than be fearful of closeness counsellors were fearful of experiencing feelings of shame. Counsellors had built aspects of boundaries into their practice unquestionably as Totton suggests. Ingham's (2010) argues that rather than boundaries being a pre-prescribed notion that all counsellors must adhere to, they should be studied and then assimilated into each counsellor's internal judgement reflecting their own interpretation and understanding of the concept. Participants in this study had already assimilated the concept of boundary into their practice. However, often their awareness of how or why they had done was missing.

This thesis found that counsellors can work defensively with boundaries when experiencing feelings of shame. Arguably, this may be the opposite end of a continuum of behaviour which has abusive counsellors who work with 'diminishing boundaries' at the other end (Hetherington, 2000; 'Poppy', 2001; Richardson, Cunningham et al, 2008; Simon, 1995). It may be that abusive counsellors are less likely to fear shame and are therefore more prone to committing such abuses as they are not fearful of being shamed by the client. This argument is further supported by the literature which states that once abusive therapists are discovered by the profession they can often continue to practice (Dore and Williamson, 2016) or deny that they have done anything

wrong. This suggests that they are also less likely to respond to feelings of professional shame. This also supports Hartmann's (1997) view that therapists with overly 'thin' boundaries are abusive because they can over relate to more positive feelings such as love and compassion in therapy whilst also avoiding more negative emotions (such as shame); whereas therapists with overly 'thick' boundaries can be abusive because of a lack compassion for their clients. These type of counsellors, are likely to be found at the extreme end of counsellor behaviour (and were not evident in these participant accounts). However, these counsellors could be further researched via the Boundary Attitude Questions.

This thesis proposes further research (and discussion) needs to be completed into the role of boundaries in defensive and potentially neglectful practice including the influences of shame and fear. This thesis also argues for further research to be completed on the role of shame and fear on counsellor training courses. The Boundary Issues Questions are useful in helping counsellors, trainers and supervisors explore areas of practice which may be being influenced by feelings of shame and fear.

The literature supports the notion of counsellors working within their boundary of competency (Reeves, 2013; Owens, Springwood and Wilson, 2012) which would suggest that the avoidance of some boundary issues was necessary. For example, if the counsellor felt that issue was beyond their capability. However, this thesis argues that when making this type of decision it must be made after a careful process of reflection with any response not only considered but also delivered in the client's best interests (whilst also keeping the counsellor safe!).

Süle (2007) proposes that in the therapeutic encounter the purpose of the boundary concept is to create three interdependent spaces for reflection. The counsellor's

reflective space, the clients and the reflective space that they share. This thesis has focussed on the reflective space of the counsellor as it has examined their experiences of and responses to boundary issues. Süle argues that "[t]he need for setting or changing boundaries usually comes because one of the spaces is not sufficient for reflection" (2007, p269). This notion is evidenced in this study as participants often changed the boundaries of their encounter with the client when they had insufficient space to reflect on the specific boundary issue they were presented with. Süle argues that if boundaries need to be changed that they should be changed "in such a way that in all the three spaces a reflection process on the experiential world of the client can develop." (2007, p269). The two models and supporting questions proposed in this thesis aim to develop this reflective space of the counsellor so that they can focus more effectively on the client's experiential world.

I identified earlier in this thesis how the BACP did not record how many of its members downloaded/requested its information sheets. This information may be useful in determining how influential they are; at least in terms of numbers of people that this information is shared with. Arguably, if the counsellors reading this information are small in number then how useful are they to the profession? And should the BACP be finding other ways of communicating this information? This information may also give insight into areas which are of interest to counsellors. Therefore, a recommendation of this thesis is for the BACP to record how many copies of their information sheets are downloaded/requested by practitioners.

Methodology Discussion

This study is approached from a critical realist perspective. From this perspective Maxwell (2012) argues that qualitative research design is viewed as a real entity rather than purely abstract or theoretical. This is from two perspectives: the actual conception

of the research (i.e. the plan by the researcher) and the conduct of the research (i.e. how it was carried out). In this thesis, these entities are different. To consider the process this research took, to represent its non-linear approach and to assess its trustworthiness I have used Maxwell's (2005) Interactive Model of Research Design. This model can be useful for planning research as well as analysing completed research (Maxwell, 2012). The model has five key components which interlink with one another which are: goals; conceptual framework; research questions; methods and validity. To understand the relationship between these components the researcher identifies what was planned and what was carried out. A summary of this exercise is detailed below.

The original goal of this study was to explore the concept of boundary from the perspective of the counsellor. This was to illuminate their understanding and experience of the concept. One of the goals was to produce a definition of 'boundary' as understood by counsellors. The main goal of this thesis remained the same throughout the process to explore counsellors understanding and experience. However, this thesis acknowledges that producing a singular definition was impossible to achieve. It was however able to represent the participants' understanding and experience of boundary.

This representation of the counsellor participants' accounts took the form of two models. The Boundary Process Map and the Boundary Response Model. Arguably, these models could be considered an abstraction too far as they have required a significant interpretation of the accounts and a high level of analysis to produce. However, one criticism of IPA research is that it is often overly descriptive with little interpretation of the data. The models produced as part of this study evidence that this study has gone further than the just the descriptive. In addition, from a critical realist

perspective the phenomena and processes in the written accounts can be considered real (Maxwell, 2012) and therefore useful. The detailed examples at the end of *chapter six* further substantiate the claims made by the two models and therefore evidence that the models produced are based very clearly within the participants' accounts.

I have also tried to reflect on my own personal goals in the writing of this thesis and the impact this may have had on the research process (both conscious and unconscious motivations). Certainly, I wished to achieve a PhD through the writing of this thesis which requires a valuable contribution to knowledge. This requirement added a certain pressure to me as a researcher and was this pressure was often felt more deeply during difficult periods of data analysis. I also acknowledge that my original motivations to research this topic began with my own negative experiences of boundaries. Acknowledging this experience led me to question my findings at various stages of this thesis. For example, my interpretation that many of the participants boundary responses were underpinned by shame could be considered a particularly deficit based analysis of their accounts. Acknowledging this at various stages of the research process I attempted to consider other aspects of the participants' accounts to not only ensure that I was fairly representing their experiences but to ensure I was not missing anything. This resulted in an expansion of the BRM on two occasions.

The conceptual framework for this thesis was to understand counsellors lived experience of 'boundary', to interpret that experience in the context of my own knowledge and experience and to focus on the individual experience of the counsellor. I would argue that broadly speaking this thesis has remained within this theoretical framework throughout its conception and delivery. However, the methodology from which I tried to complete the research was problematic.

Despite IPA resulting from the above conceptual framework (i.e. a phenomenological, hermeneutic and idiographic approach) it was limiting in this research because of its focus on themes. Although many of the themes were identified in all of the accounts they were often with little depth (i.e. examples for each theme existed but weren't necessarily rich in detail). The methodology was therefore useful as an analytical process because it enabled me to take apart the accounts. However, it failed to represent them fully. In this case my search for trustworthiness (or validity) of the accounts led me to additional methods (such as the pen portraits).

The process of interviews appealed to me as a data collection method because of my own experience as a counsellor. However, the boundary between interviewer, researcher and counsellor was difficult to define during interviews as my use of counselling skills often fed over into my interviewing skills. I also feel that when analysing the transcripts, I noticed missed opportunities for exploring some areas more thoroughly (despite the rich data that I still gathered). I would also have liked to explore the concept of 'boundary issue' in a more proactive way.

The data from the participant accounts was rich. This meant that it could have been analysed and interpreted in numerous different ways. For example, the unconscious motivations of participants played such a big role in their accounts that they could have been analysed through a psychoanalytical perspective. However, I believe that the findings presented here do represent a valid interpretation of the participants' accounts.

The role of my supervisory team was integral to my analytical process as I entered into detailed discussions about my findings and interpretations of accounts. Agreement was not always possible. However, this process helped me clarify my own

process and question each aspect of my findings. The use of detailed examples in the findings section is important for showing various aspects of the models being applied in detail. Rather than evidence many examples across the accounts this thesis has explored specific examples in detail. This has been the benefit of using a small sample size that provided rich data.

Limitations of this thesis

There are numerous limitations to this study.

This study aimed to research counsellors understanding and experience of the concept of 'boundary'. In this respect, the study achieved many of its aims and objectives (a summary of these is given in the next chapter). However, I was acutely aware throughout the completion of this study that the client's perspective was often absent in my discussions. I am unable to know the impact of participants' understanding and attitude towards boundaries and their experience and response to boundary issues on the client because their perspective was not explored in this study. Although participants of this study did discuss examples from their client work within their accounts I was surprised that they did not discuss more examples or go into details about the impact on their clients. Arguably, this was not what was asked of the participants as they were asked for *their* understanding and experience of boundary not their clients. However, it was still surprising that this perspective was not referenced more from a group of professionals who are used to personal reflection and empathic understanding of others. Clearly, any use of client examples also raises the issue of confidentiality in counselling research (Bond and Mitchels, 2015) and this may have been another reason for this aspect not being explored as much as expected. Nevertheless, I would suggest that further research needs to be completed

into clients understanding and experience of the boundary concept as well as their experience of counsellors' boundary issue responses.

The extremely small sample size used in this study (although necessary for the detailed exploration of the counsellors' accounts) is not of sufficient size to enable a generalisation of findings to the population of counsellors in the UK. This means the validity of these findings as representative across the population would needed to be tested through further research studies. Similarly, the validity of the proposed models also needs to be tested in the wider population of counsellors. Due to the nature of the models themselves this testing would need to be completed qualitatively. This could be done by presenting these models to practitioners on training days and conference workshops, or consideration by expert panels.

Although the participant sample in this study is broadly homogeneous (i.e. qualified and practicing counsellors) I am aware that other qualitative (particularly IPA researchers) may criticise this research because the sample was not homogeneous enough (for example a sample of all female person-centred counsellor who were qualified and practicing for 10 years). Although there may be benefits to completing this type of research the findings could still not be generalised across that specific population (i.e. female person-centred counsellors etc) because of the small sample size. A more closely homogeneous sample may raise potentially new insights into that specific population which would lead to potential new research areas. However, this is a matter of directing future research rather than generalisability. Furthermore, the sample used in this study allowed exploration and comparison of counsellors with multiple modalities which also brought new and interesting insights to this study. I do not think this study was limited in anyway by the type of sample that was used.

Finally, this thesis has used a very broad definition of 'shame' that incorporates feelings of shyness, guilt and embarrassment. There is detailed literature which argues that these emotions are distinct from each other and are not necessarily all part of the shame affect. I have given great consideration into the use of such a broad definition of shame as proposed by Nathanson (1992) and still argue that it is a useful and necessary application in this thesis. This admittedly very broad definition of shame has enabled the experiences of counsellors in this study to be drawn together. It has therefore helped raise questions about the role of personal and professional shame in response to boundary issues. Readers of this thesis may challenge some of the participants examples detailed as examples of shame. Indeed, Parker (2005) advises that IPA researchers may unintentionally find meaning in participants accounts that do not exist for the participants. Many of the examples are not 'obvious' experiences of shame and have required a more detailed analysis and interpretation from the researcher to evidence the shame affect more clearly in these accounts. However, I argue that they are indeed there.

Where do I now draw the line?

Looking back on the completion of this thesis I acknowledge how far I have come as a researcher. The journey has been particularly challenging for many reasons. The concept of 'boundary' is one that is particularly challenging and complex to explore because of its multifaceted nature. My own personal experience of it as a trainee counsellor, a qualified counsellor and as a researcher is a testament to this. However, I feel that this thesis has evidenced that complex concepts can be explored and new insights found through detailed qualitative analysis.

Although I started this thesis with the question 'what are boundaries in counselling practice?' I acknowledge now a more useful question to ask counsellors would be

'what are *your* boundaries in *your* practice?' I also questioned my own boundaries at the start of this thesis and asked myself - 'where do I draw the line?' I did not fully appreciate this question at the beginning of this research journey. If I am honest then I thought that this question should be answered by the profession itself. That is that the profession should be defining the limits of my own (and other counsellors) interactions with our clients. Certainly, the profession has a responsibility to research and communicate what is unethical and dangerous practice. However, each professional also has a responsibility to reflect upon their own practice and how it impacts on the client. Including their understanding of boundaries and their response to boundary issues. I now consider this question in terms of my own personal limits as a counsellor. I now appreciate that this question needs to be considered much more regularly in my counselling practice to ensure that the line I draw is being drawn clearly and transparently for my clients. It has also made me question my own practice when responding to boundary issues and encouraged me to more regularly reflect on my own motivations for my responses.

Chapter Eight: Conclusions

The research and writing process which I have gone through during the production of this thesis has been both challenging and enjoyable. Whilst I set out with very clear ideas about what I wanted to achieve with this thesis I ended up delivering something very different and exploring many different avenues which were not predicted at the start. I have also managed to learn a great deal about adapting qualitative research methods to the subject I am investigating.

This chapter will conclude this study by reviewing the Aims and objectives set out at the beginning of this thesis and considering how far I have been able to achieve them. I will then summarise my reflection on the whole research process including my own learning and development as a researcher. Finally, I will summarise the contributions to knowledge that this these has provided.

Aim One - to examine and explore the development of the concept of boundary within the field of counselling in the UK as well as identify the main themes within the literature.

The thesis aimed to explore the concept of 'boundary' within counselling in the UK. It was impossible to consider the literature on boundaries because it covers such a broad expanse. Furthermore, it is also difficult to just focus on the literature from the UK because this literature has often been heavily influenced by literature in America. Rather than focus on 'themes' the review of the literature was broken down into five main discussion points which are often raised in discussions of boundaries (e.g. McLeod, 2013; Proctor, 2014). These main discussion points were: *Boundaries and Counselling Ethics*; *Exploitation and Abuse*; *Boundary Issues*; *Types of Boundaries*; and *An Alternative View of Boundaries*. This exploration of the literature therefore achieved aim one of this thesis.

Aim Two - to explore counsellors' understanding and experience of the boundary concept in their practice.

The second Aim of this thesis was to explore counsellors' understanding and experience of the concept of 'boundary' in their counselling practice. This thesis has achieved this aim through an exploration of seven qualified and practicing UK counsellors' experiences of boundaries. The detailed analysis of these accounts has resulted in new insights surrounding boundaries and new potential areas for study and recommendations for practice. The outcomes of this exploration have gone towards achieving the objectives for this study.

Objective 1: to produce a definition of 'boundary' from a counsellor's perspective.

This objective was not achieved because the participants' definitions and understanding of 'boundary' were found to be unique. However, this finding is usefulleads this thesis to suggest that counsellor training and supervision should acknowledge the idiosyncratic nature of boundary for counsellors. This would enable a more honest discussion around boundaries. Furthermore, it is likely to reduce the role of shame in influencing boundary responses to boundary issues as discussion would centre on the difference between counsellors and contexts rather than expectations of the profession.

Objective 2: to represent counsellor participants' understanding and experience of the concept of 'boundary'.

This thesis has used the participants' accounts to formulate two models of boundaries. The first is a process map of how counsellor participants approached and responded to boundary issues. The second is a model of how counsellor participants respond to specific boundary issues. These models are from the practitioner perspective rather

than a top down perspective. They highlight that: counsellors often experienced shame and fear when confronted with boundary issues and how counsellors *responded* to boundary issues was often a more useful exploration than how they defined boundaries.

Objective 3: to compare counsellor participants' understanding and experience of boundaries with the current literature on boundaries;
Objective 4: to inform knowledge in this area (which includes counsellor and therapist training);
Objective 5: to identify any potential new areas for future study.

In chapter seven of this thesis the findings of this study are discussed in relation to the current literature on boundaries. This discussion highlights how the proposed models and the supporting questions are a valuable contribution to knowledge which could support counsellor and therapist training and development once the models are validated.

This thesis argues that counselling course facilitators and supervisors need to understand how their students or supervisees define boundaries and what they understand them to be. Counselling courses need to support trainee counsellors in understanding that each person has their own definition of 'boundary' which is not necessarily the same as their fellow students, and may not be something that necessarily follows what is written in the counselling literature. This is to ensure that there are no misconceptions or assumptions made about what is being referred to or discussed during training and supervision. This also allows individuals to consider their own understanding of boundaries and is a starting point in developing more detailed reflective discussions about boundaries.

The term 'boundary issue' should be used to refer to **<u>any</u>** aspect of counselling that impacts on the therapeutic encounter. Future counsellor training, supervision and research needs to focus on how counsellors respond to boundary issues to further illuminate new insights into boundary theory and support counsellors in developing their skills in relation to boundary issues.

This research has found that counsellors have their own specific approach towards boundaries which consists of multiple elements that are individual to that specific counsellor. This has been labelled the counsellors **'boundary attitude'**. Future training and supervision should focus on developing counsellor awareness of their boundary attitude and the impact it has on their counselling practice. This can be done through the Boundary Attitude Questions highlighted in the previous chapter. This would support counsellors to have more awareness about their general approach to boundaries and support them to make better decisions around boundary issues. If a counsellor's understanding of and response to boundaries is idiosyncratic and not related to therapeutic tradition (as proposed by this thesis), then trainers and supervisors should not make any assumptions about a practitioner's knowledge, understanding, and experience of boundaries or their approach to them.

Future training and supervision should focus on developing counsellor awareness of their experiences of shame and the propensity for this to influence how they respond to boundary issues and the impact it has on their counselling practice. Supervisors needs to be aware that personal values and beliefs about boundaries are more likely to influence a counsellor's boundary responses and therefore explore these in supervision.

The risk of boundary responses becoming standard practice of counsellors when faced with similar boundary issues needs to be considered in supervision. This is particularly relevant for experienced counsellors who may have built up a comfortable and established repertoire of boundary responses that have 'worked' in the past.

Facilitators of counselling courses need to be aware of the potential for trainee counsellors to 'cherry pick' aspects of boundary training that fit in with their own boundary attitude. If this happens then trainees will just be reinforcing their established boundary responses or their current tendencies. Therefore, any training needs to ensure that trainees are given the opportunity to consider the numerous ways that boundaries can be used to influence the therapeutic encounter and the various responses that can be made to boundary issues.

Supervisors and trainers should support counsellors to distinguish between therapeutic interventions that actively seek to protect the counsellor through reflective practice versus defensive practice which may compromise the therapeutic encounter.

The BRM (and supporting Boundary Issue Questions) can be used to analyse individual boundary responses by practitioners, trainers or supervisors. This is useful in raising awareness with counsellors about the role of shame in their practice and the risks and signs of defensive practice. It also enables counsellors to consider alternative responses to boundary issues. This would support counsellors to have greater awareness about their general approach to boundaries and support them to make better decisions around boundary issues. Future research needs to examine how counsellors experience shame within their practice and how social processes contribute towards counsellors' decision making. Future research also needs to further consider the role of shame in defensive practice for counsellors at the practice and

organisational level. To develop this study further investigation needs to be completed into how the responses of the BRM correlate with the broader population of counsellors in the UK.

Finally, further exploratory and qualitative research needs to be completed into boundary issues and counsellors' responses to them.

Other contributions of this research.

As discussed in chapter three for this thesis IPA has been found to have significant limitations when researching complex and multifaceted concepts. The focus of IPA to deliver ever reducing themes felt restrictive and limiting when exploring the concept of boundary in this study. Initial analysis of the first participant's account resulted in 42 individual themes. The difficulty in reducing these down to a few was daunting when all seemed pertinent and relevant with comparable themes also highlighted within the counselling literature. In addition, the focus on 'themes' meant that the researcher was drawn towards areas which are more commonly represented within the accounts. This does not necessarily result in better analysis or necessarily result in new insights for the researcher. The trend for IPA to focus on common themes across accounts is further advanced by Smith's requirement for 'good' IPA research papers to evidence themes across a certain amount of accounts to be called a theme. For many of the participants in this study there were small nuanced themes which were only relevant to the individual account. Furthermore, by attempting to broaden out the themes to include as many accounts as possible meant that the individual stories of the participants was at risk of being lost in the final analysis. It could also be argued that this study had yet to reach 'saturation' with its themes with new insights constantly materialising and that a larger sample could have been used. However, the concept of boundary was so complex that it provided extremely rich data to analyse which

could only be completed satisfactorily through the deep analysis of the individual accounts. The analysis presented in this thesis is only one approach that could be used to interpret this data. For example, another approach could have considered analysis from a psychoanalytical perspective as many of the accounts appeared to show underlying unconscious motivations towards their use of boundaries.

IPA is supposed to focus on the lived experience of the participants without bias of the researcher, other research or the other narratives (Smith, Flowers, Larkin, 2009). However, this is an impossible and extremely limiting position for the researcher. The new insights delivered in this thesis have only been possible through adding additional areas of analysis to the IPA process. For example, the theme of 'shame' was initially identified as a small aspect within the participants' accounts. However, through researching shame I found a much broader definition of shame which incorporated other aspects of the participants' accounts. The accounts were reanalysed using this definition which resulted in a deeper analysis of the data. Other techniques have also been used within this study to provide more detailed insights such as the use of pen pictures.

In IPA sample groups are so small that they can never be considered 'representative' of any group (Smith, Flowers, Larkin, 2009). However, the requirement for 'homogeneous' sampling in IPA research can lead to researchers assuming that sample groups are in some way representative. Therefore, researchers may become overly focussed on matching demographical differences between participants to create a 'homogeneous' sample rather than focussing on the broader key characteristics important for the study. For example, in this study it was important to ensure that participants were qualified and practicing counsellors. By focussing on small groups with similar demographical characteristics researchers may miss

opportunities to consider broader commonalities and differences between accounts which can bring new insights. For example, in this study the various therapeutic backgrounds of participants contrasted with their approach to boundaries. This new insight would not have been highlighted had all participants been purely person-centred counsellors. This insight cannot be argued to be representative of all counsellors. However, it can be used as a potential indicator of and area for new research.

Despite the complexity of the concept of 'boundary' and the relatively small sample size of participants of this study this thesis has shown that valuable insights can be provided into complex concepts from small scale qualitative enquiry if the level of analysis is detailed enough.

Methodological Recommendations

Qualitative research should not shy away from investigating challenging, multi-faceted and complex concepts because current research methods do not lend themselves to this type of enquiry.

Researchers should make attempts to tackle these investigations but in new and innovative ways. This may be through using multiple methods or trial and error analysis of data with different qualitative methods.

Future research should complete qualitative studies with small numbers of participants (despite the challenges that this brings) to examine complex concepts (such as boundaries) so that it can generate new areas of discovery and indicate potential new lines of research.

The issue of homogeneity in IPA research needs a much greater level of discussion in the literature as there is limited guidance for IPA researchers. The current literature

focusses on the demographical similarity of participants taking part in any study. However, current guidelines do not allow for broader sampling of participants which in my opinion can limit some types of enquiry.

In this chapter I have detailed how I achieved the aims and objectives of this study. In the previous chapter I discussed the pertinence of the findings of this thesis. I summarise below the contributions to knowledge that this thesis has made:

Summary of Contributions to Knowledge

Boundary Attitude

1. The participants of this study (qualified and practicing counsellors) had no common definition of the concept of 'boundary'. Each participant's understanding of the concept was **idiosyncratic** (i.e. specific and personal to them).
2. A 'boundary issue' should be defined as **any** aspect of counselling which impacts on the therapeutic encounter (e.g. events, questions, topics, dilemmas, transgressions, and violations). This is to ensure discussion of boundaries is not overly focussed on abusive practice.
3. Counsellors found it difficult to define boundaries but were easily able to articulate how they **responded** to 'boundary issues'.
4. Counsellors have their own unique *general* approach to boundaries – this thesis has called this their **'boundary attitude'**.
5. The greatest influence on the counsellors' **boundary attitude** was their own values and beliefs surrounding boundaries. Although any training and counselling experience of boundaries also played a part.
6. The therapeutic tradition of a counsellor does not necessarily correlate to their **boundary attitude**.

Shame, Defensive Practice and Thickened Boundaries

1. Counsellors' **feelings of shame** (or their apprehension of feeling shame) is a highly influential factor in how they respond to boundary issues.
2. Counsellors will respond to boundary issues with **defensive practice** when they experience feelings of shame or are fearful of experiencing shame. This results in a reluctance on behalf of the counsellor to actively engage with the issue (now or in the future) and reflect upon an appropriate therapeutic response because of the fear of being shamed.

3. Counsellors can use a thickening of boundaries to protect themselves from the threat of experiencing shame. This is usually an emotional distancing of the counsellor from the client but could also include other elements such as physically removing themselves from the therapy.

Additional

1. There are currently no tools that support counsellors to make boundary decisions that is based in counsellors understanding and experience of boundaries. To address this gap this thesis has created two models a **Boundary Process Map** and **Boundary Response Model (BRM)** which identifies how counsellors respond to boundary issues.
2. These models have spurned two sets of questions **Boundary Attitude Questions** and **Boundary Issue Questions**. These can be used by counsellors, supervisors and trainers to support counsellors in exploring their general attitude and understanding towards boundaries whilst also exploring their response to specific boundary issues. The Boundary Issue Questions can also be used as an exploratory tool to consider different areas of practice.
3. A counsellor may respond to a specific boundary issue in a different way from how their **boundary attitude** would suggest.

Methodological Contributions to Knowledge

1. IPA has significant limitations when researching concepts which are complex and multifaceted.
2. Homogeneous sampling in IPA research can limit new insights into participants' accounts when it becomes overly focussed on matching the demographical differences of participants.
3. Separate from the other methodological items this thesis shows that qualitative research with only a small number of participants can provide valuable insights into complex concepts.

What now?

In this chapter I have reflected on the effectiveness of this thesis in achieving the aims and objectives set out at the start. I have summarised the contributions to knowledge that this thesis has made and indicated ways this knowledge could be used to support counsellors in their training or practice. I think it is important to note here in the final summary of this thesis that this study has been an exploratory and detailed study of counsellors' lived experience of the concept of 'boundary'. Many of the findings could

only have been produced from such a detailed analysis because they required detailed reading, exploration and interpretation. The best example of this is the role of shame in the participants' accounts which is not immediately obvious without analysis and interpretation. These findings cannot be generalised because they are based in such a small population of counsellors. Indeed, this was not an aim of this thesis. However, I argue that it has offered new insights into the concept of 'boundary' and provided a variety of new potential areas of study. This thesis argues that the boundary concept has been a neglected area of study in terms of counsellor understanding and experience because of its complicated and multifaceted nature. As the profession gives no indication that 'boundary' is a concept that it wishes to stop using then this is a gap in the research that needs to be addressed. Therefore, this thesis is one step closer to addressing this gap.

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Appendices

Appendix A - Extent of Abuse in the UK

Appendix B - Sexual Boundary Violations

Appendix C - Why do boundary violations occur?

Appendix D- Pluralistic boundary decision making guide

Appendix E – A sample information sheet

Appendix F – A sample informed consent form

Appendix G - Interview Prompts

Appendix H - Summary of Characteristics of Each Boundary Response

Appendix I - Reacting Defensively to Shame – Compass of Shame

Appendix A - Extent of Abuse in the UK

To ascertain the extent of abuse and exploitation by counsellors in the UK is problematic due to the lack of research available. This also makes it difficult to assess the role of boundaries in the prevention of exploitation and abuse of clients. Certainly, there is a greater awareness of therapist abuse in the UK. This may be, in part, due to the high profile of some cases within the British media (e.g. Luck, 2014).

In a survey by MIND of 181 service users of mental health services 38% reported that they had experienced some form of abuse from a counsellor or therapist with the breaking of professional boundaries being the most common aspect of their experiences (MIND, 2010).

Examining complaints made against therapists may be a good indicator of the extent of boundary abuse by therapists in the UK in the absence of specific research. However, research suggests that abuse by therapists is likely to be under reported (Halter, Brown and Stone, 2007; MIND, 2010). One survey found only 20% of those people who felt they had experienced abuse by a counsellor or therapist actually made a complaint against them and this was for a variety of reason's including the fear of not being believed through to a lack of knowledge or opportunity to access the complaints process (MIND, 2010). Furthermore, the majority of those (nearly three quarters) who did make a complaint did not feel satisfied with the outcome (MIND, 2010).

Although all complaints are unlikely to be boundary related they can offer a representation of when clients may have felt boundaries were breached in therapy. Due to the space limitations of this thesis any detailed examination here may take the reader away from the intended focus on boundaries, therefore a brief summary is

provided. For a detailed exploration of the literature on complaints please refer to Symons (2012).

Up to date statistical evidence regarding complaints against BACP counsellors is limited. However, two previous studies give us some information, although these are between 8-9 years old so cannot provide an up to date picture. Research into complaints against BACP counsellors between 1996 and 2006 found that 35% complaints were about counsellor responsibility (such as managing breaks/endings; financial and emotional exploitation; and conduct undermining public confidence in counselling) (Khele, Symons, & Wheeler, 2008). The same research identified that 12% of complaints were about boundaries (it is unclear why the previous complaints were not considered boundary issues). With these complaints 76% were upheld suggesting that the majority of complaints about boundary misconduct were of such significant concern that they were sustained. Research (representing data from 1998-2007) into allegations of 'serious professional misconduct' by BACP members found 56 to be upheld (out of 91 reported cases) (Symons, Khele, Rodgers, Turner and Wheeler, 2011) though after appeals this translated into only 33 memberships being terminated. Alarmingly, Dore and Williamson (2016) found that approximately 23% of counsellors/therapists or organisations who had been 'struck off' the membership list of the BACP and UKCP over a ten year period (2005-2015) were still advertising their services suggesting they were still in practice.

So, the extent of abuse by counsellors and therapists towards their clients within the UK is unclear, and current statistics will not show the true extent of therapist abuse because incidents are often unreported. However, research suggests that abuse by counsellors and therapists is often related to a breach of boundaries by practitioners.

Appendix B - Sexual Boundary Violations

The issue of sexual exploitation of clients gathered momentum over a period of approximately ten years, when various publications highlighted the issue during the 1970's (Bates and Brodsky, 1989). There were only four cases of 'sexual intimacy' investigated by the American Psychological Association (A.P.A.) Ethics Committee during the period of 1970-1974 (Brodsky, Holroyd, Sherman, Payton, Rosenkrantz, Rubinstein and Zell, 1975), and by 1987 cases of sexual misconduct made up the majority of their reported cases (Bates and Brodsky, 1989). Early texts on the subject focussed on exploring the extent of the problem and how widespread it was in various professions (e.g. Gabbard, 1989); some considered experiences of clients (e.g. Freeman and Roy, 1977), whereas others also highlighted elements of the therapist experience (e.g. Rutter, 1991). For a history of the development of literature in this area please see Gutheil and Brodsky (2008) or Pope and Vasquez (2016).

Inappropriate sexual behaviour is now viewed as violating a professional boundary (BACP, 2016a; Kent, 2013), despite an attempt during the 1970s by some therapists who tried to argue that sex with clients could have a therapeutic effect (Bates and Brodsky, 1989). Many ethical frameworks did not renounce inappropriate sexual behaviour in their codes until much later than this (Bates and Brodsky, 1989). Sexual activity was prohibited with clients in the first ethical code of the BACP (previously known as the British Association of Counselling – BAC) produced in 1984 and was then repeated in other UK ethical codes such as UKCP and COSCA (Bond, 2015).

Despite an increased level of focus on sexual boundary violations in therapy since the 1970's, and a much more comprehensive literature base, there is still a lack of clarity regarding what constitutes a boundary violation with regard to sexual behaviour. The BACP (2016a) ethical code advises counsellors that they must not engage in: the

sexual abuse of clients; sexual relationships or sexualised behaviour with clients or people closely associated with their clients. Despite a better understanding of their nature they can still create and cause ethical dilemmas within the field. For example, there are still debates surrounding what is inappropriate sexual contact and whether sexual relations are allowed with individuals who were previously clients (Bond, 2015). Furthermore, understanding of what factors contribute to sexual boundary violations is still relatively limited. Bond (2015) highlights a deficit in counsellor training courses about how to handle feelings of sexual attraction towards clients as one area of concern.

As previously identified the prevalence of exploitation and abuse by therapists in the UK is unclear, this includes the extent of sexual abuse of clients by their therapist. Sexual exploitation of clients by counsellors and therapists in the UK is under researched compared to other associated professions (Halter, Brown and Stone, 2007). Garrett (1998) surveyed clinical psychologists and found 4% had engaged in sexual activity with their clients, and nearly 23% had treated a patient who had been sexually involved with a previous professional (including psychiatrists, psychotherapists, nurses and social workers). Halter, Brown and Stone (2007) found a significant level of under reporting by clients who were sexually abused by professionals. Complaints to the BACP about sexual exploitation by therapists is relatively minor (Khele, Symons and Wheeler, 2008) compared to say the figures in the USA.

Appendix C - Why do boundary violations occur?

There is a lack of understanding of why counsellors end up in difficulties with boundaries when they apparently have a good knowledge and understanding of what is expected from them, often they can refuse to stop or try and validate their involvement (Webb, 1997). A boundary violation occurs when "the therapist acts on the basis of his or her own needs or desires rather than the client's needs and best interests" (Hartmann, 1997, 155), however the counsellor might be unaware that he or she is putting their needs first. So, Bond (2015) advises that counselling requires "careful monitoring of boundaries of responsibility in order to ensure that these are not becoming blurred" (p279). Dale (2016) states "practitioners with clearly expressed boundaries are less open to manipulation, either conscious or unconscious, and more able to enter into a working alliance that is free from psychological game playing" (p12).

Survivor stories of abuse and exploitation by professionals are painful reading, and highlight the significant impact that such abuse can have (Richardson, Cunningham et al, 2008). Each of these stories highlights professionals breaching the trust implicit within their role, and exploiting their clients through sexual, psychological and financial abuse. In each case the perpetrator has broken the boundaries of their professional role. One of the most common aspects of survivor stories is their references to the consistent removal or reduction of professional boundaries over time (Richardson, Cunningham et al, 2008; 'Poppy', 2001). Hetherington (2000) states that these "[d}iminishing boundaries serves to break down client resistance" (p15). Simon (1995) proposes an inventory of these diminishing boundaries, a 'slippery slope' that often follows a specific pattern of boundary erosion leading to eventual violation. Totton (2010) acknowledges that the boundary concept was taken from the work of survivors

of sexual abuse and although useful in that context has actually reaffirmed the idea of the 'slippery slope' argument. That is the notion that any breaking of boundaries leads counsellors down a 'slippery slope' towards more harmful boundary abuses towards clients. Totton refutes this principle arguing that it is unjustified to use this in all contexts.

Alternatively, Hartmann (1997) argues that boundary violations in therapy occur when individuals have particularly extreme boundary elements to their personality. Three types of individual are identified which are the client with particularly 'thin' boundaries or the therapist who has either particularly 'thin' or 'thick' boundaries. The argument here is that clients with 'thin' boundaries are of a particularly vulnerable nature, more exposed and trusting of their therapist, and therefore more vulnerable to boundary abuse. However, this argument is particularly disturbing in the fact that it could be interpreted as the client being responsible for the abuse, because of their lack of boundaries. Never the less some clients are considered to be of higher risk of exploitation by therapists such as those who have a history of incestuous relationships (Gabbard, 2016). In psychoanalysis Gabbard (2016) argues that this is "the boundaryless situation of childhood" (p33) being re-enacted in therapy.

However, the therapist is deemed to be more susceptible to breaching boundaries within therapy because of having either too thin or too thick boundaries (Hartmann, 1997). The more substantial sized group is said to be therapists with boundaries that are too thin. This group is said to 'overvalue' the empowering love affect and positivity within the counselling room, and avoiding negative emotions. In contrast, the smaller group is argued to have a complete lack of love or compassion for their clients, i.e. their boundaries can be too 'thick'.

Situational factors are also considered in influencing abuse in therapy however Hartmann argues that it is mainly aspects of the individual's personality that has the greatest authority. If we accept this argument, then it brings into question the appropriateness of additional training and the discussion of boundaries as a tool in reducing boundary abuse, because the abuse of boundaries is a result of elements of a client or therapists personality.

Appendix D- Pluralistic boundary decision making guide

Information gathering	Planning an approach	Monitoring and evaluation
• What is the issue? • What does the client want? • What does my profession say? • What does the law say? • What does the research say? • What would a respected colleague say?	• What are my options? • What are the short- and long-term consequences of these? • Which ones will help my client learn to get along without me? • What are the legal, professional and ethical implications of these? • What's the best way forward?	• What happened? • What was effective? • What could be improved? • What else needs to be done? • What have I learned? • How would I handle a similar situation in future?

Table 2: A decision making guide to the flexible and responsive application of therapeutic boundaries, taken from Carey (2016)

MANCHESTER METROPOLITAN UNIVERSITY

MMU CHESHIRE

Department of Interdisciplinary Studies

INFORMATION SHEET

You are invited to take part in some research within the field of counselling. Before you decide whether or not to take part it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully. If you have any questions or would like to discuss this further then do not hesitate to contact me on the supplied details. Once you have read and understood the information provided and wish to take part then please complete and sign the consent form provided.

Thank you for considering participation

What if I do not want to take part?

Participation is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part then you are still free to withdraw from the study at any time and without reason. A decision to withdraw from the study at any time will have no adverse effects.

What will happen if I take part?

You will be asked to attend an informal interview of approximately one to two hours long which will discuss your thoughts and experiences of 'boundaries' within your counselling practice. This interview will be recorded for later analysis.

What are the possible disadvantages and risks of taking part?

Participants will be asked to recall experiences and events which have occurred during counselling relationships and should be prepared for any emotions or unresolved issues that this may invoke. Participants will be referred to appropriate agencies in specific circumstances.

What are the possible benefits of taking part?

There are no anticipated benefits to you taking part, except furthering research within the field of counselling.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research process will be kept strictly confidential and will only be used for the purpose of the study.

Will I be identified in this study?

Personal information will not be available and all participants will remain anonymous. However, quotes from the interviews will be used in the research reports.

What if I want to complain?

The study will be supervised by Doctor Kathy Kinmond, any complaints should be directed to her in the first instance.

Tel: ***********   Email: ************

If you have any further questions or require any additional information before making a decision then do not hesitate to contact me on any of the details below.

Yours Sincerely

Peter Blundell

Research Student MMU

▪▪▪

Peter Blundell,

Tel:

▪▪▪

Appendix F– A sample informed consent form

MANCHESTER METROPOLITAN UNIVERSITY

MMU CHESHIRE

Department of Interdisciplinary Studies

Research: The Concept of 'Boundary' in Counselling.

CONSENT FORM

Please confirm that you have read and understood the requirements of this study by initialling the box after each statement. Then sign and date below to confirm that you wish to take part.

- I confirm that I have read and understood the information sheet   **Initial**

  for the above study and have had the opportunity to ask   **Boxes**

  questions   ☐

- I understand that my participation is voluntary and that I am

  free to withdraw at any time without giving reason and

  without any adverse effects.   ☐

- I understand I will not be identified in the study.   ☐

- I agree to quotes being used from my interview within

  the study.   ☐

- I agree to take part in the above study.   ☐

*Please sign if you are in agreement with **all** of the above points and wish to take part*

in the study.

Signed_____Date_____

The Concept of 'Boundary' within Counselling.

Questions and Prompts.

Knowledge and Understanding

- What does the term boundary mean to you?

- How important do you think boundaries are within the field of counselling?

- How important are boundaries to your counselling practice?

Experience

- What boundaries have you experienced between the client and yourself?

For each boundary mentioned:

- o How did (or does) it affect the counselling relationship/session?
- o How is this boundary created?
- o How is this boundary maintained or broken? (ie dependant on what that boundary is)
- o How important is this boundary?

- How do you feel about boundaries within the counselling relationship?
- How important are boundaries within your counselling work?
  - o Do you have any examples?
- How do boundary issues influence your counselling work?
  - o Do you have any examples?
- What role do you have in creating/maintaining these boundaries?
- What role does the client have in creating/maintaining these boundaries?
- What are your experiences of boundaries being broken within the counselling relationship?

Appendix H - Summary of Characteristics of Each Boundary Response

PROTECT OTHER	AVOIDANCE	ATTACK SELF	CHALLENGE
No threat to self	Unconscious threat to self	Conscious threat to self	Conscious threat to self
Conscious threat to other	Unconscious threat to other	No threat to other	Conscious threat to other
Confidence in Practice	Feelings of Incompetence	Feelings of Incompetence	Confidence in Practice
Client Empathy	Feelings of shame	Intense feelings of shame	Client Empathy
Reflective response to the issue	Slow movement away from the issue	Quick movement away from the issue	Reflective response to the issue
Thickening of boundaries (around client)	Thickening of boundaries (around self or client)	Thickening of boundaries (around self)	Thickening of boundaries (around therapy)
Defensive reaction	Defensive reaction	Offensive reaction	Involved reaction
Acknowledgement of the Issue	No or minimal acknowledgement of the issue	Acknowledgement of the Issue	Acknowledgement of the Issue
	Denial of Problem	Blaming self	
Uncomfortable Feelings	Uncomfortable Feelings	Uncomfortable Feelings	Uncomfortable Feelings about the issue
Fear for client	Fear for self, or client	Fear for self	No fear
Emotional Availability	Emotional Distancing	Emotional Distancing	Emotional Availability
Maternal instinct	Avoiding Issue	Self-loathing	Open challenge of the issue (without hidden meaning)

ATTACK OTHER	ENGAGEMENT	PROTECT SELF	WITHDRAW
Unconscious or Conscious threat to self	No perceived threat to self	Conscious threat to self	Unconscious threat to self
No threat to other (creates threat to other)	No perceived threat to other	No perceived threat to other	Unconscious threat to other
Feelings of Incompetence	Confidence in Practice	Confidence in Practice	Feelings of Incompetence
Intense feelings of shame	Client Empathy	Client Empathy	Intense feelings of shame
Quick movement away from the issue	Reflective response to the issue	Reflective response to the issue	Quick movement away from the issue

Thickening of boundaries (around self)	Thinning of boundaries (between counsellor and client)	Thickening of boundaries (around self and therapy)	Thickening of boundaries (around self or client)
Offensive reaction	Engaged reaction	Defensive reaction	Defensive reaction
No or minimal acknowledgement of the issue	Acknowledgement of the Issue	Acknowledgement of the Issue	No or minimal acknowledgement of the issue
Blaming other			Denial of Problem
Uncomfortable Feelings	Counsellor feels comfortable	Uncomfortable Feelings	Uncomfortable Feelings
Fear for self	No fear about client response	Fear for self	Fear for self or other
Emotional Distancing	Emotional Availability	Emotional Availability	Emotional Distancing (or withdrawal)
Anger	Open discussion about the issue with client	Amoeba Principle in Action	Ending Sessions/Service

Table 3: Summary of Characteristics of Each Boundary Response

Appendix I - Reacting Defensively to Shame – Compass of Shame

The development of the BRM resulted in identifying the common aspects of participants experience and combining them together into one model. A key aspect of this model (which underpins its structure) is the *Compass of Shame* as proposed by Nathanson (1992). This model sets out four different ways that individuals defend themselves against the shame-humiliation affect. The proposed model is aimed at broadening our understanding of how individuals respond to the shame-humiliation affect. Nathanson hopes that this will help psychotherapists in terms of understanding their clients, and ways of working with shame-humiliation in therapy. However, Nathanson also aims to create a much broader understanding of shame-humiliation and the impact it has on self. Developing his thesis, I will explore this model in terms of how it could help our understanding of counsellor reactions within therapy, particularly surrounding boundary issues.

To defend ourselves against shame-humiliation Nathanson proposes that we use four main reactions which help defend the self against the shame affect, a model he calls The Compass of Shame. These four reactions are: withdrawal; avoidance; attack self; and attack other. Nathanson says that "[e]ach of these categories represents an entire system of affect management, a set of strategies by which an individual has learned to handle shame affect" (p311).

The withdrawal response has two purposes, it gives the individual time to recover and can protect them from further hurt (i.e. affect reduction and affect avoidance). Therefore, minimising the experiences of shame. It can be swift, and occasional and appears on a spectrum, for example an individual may avert their gaze through to chronic depression. Mild withdrawal, according to Nathanson, can be considered 'normal' in response to some experiences of shame.

The avoidance response aims to reduce, minimise or 'shake off' the shame affect. It is characterised by slow and deliberate movement away from an uncomfortable situation. The individual is attempting to protect their personal world, through either fooling themselves or others (or both). Again, mild avoidance can be considered 'normal'.

The attack self response aims to avoid the isolation of withdrawal, and take control of the shame affect by experiencing the feelings of shame fully. However, it is important that others know that the person is experiencing this shame, and is a voluntary response aimed at building relationships with others.

The attack others response occurs when avoidance has not been enough, or has been unable to help. It is an externalisation of the shame affect aimed at blaming others.

The responses to shame identified in the Compass model could broadly be seen in the participant's accounts. However, there were three main problems with transferring this model directly to the participants' experience of boundaries. The first was that this model only focused on experiences of shame whereas the participants' accounts also identified fear and feelings of incompetence as important emotional responses. The second was that participants' response to boundaries had a much broader array of aspects to it than was identified in the Compass model. The third problem was that

this model focused predominantly on defensive responses to shame whereas the participants' responses to boundaries was much broader than this. Therefore, further adaptation of this model was required to accurately represent the participants' response to boundaries.

I have highlighted how participants used boundaries as part of their defensive practice. That is a way to keep themselves safe. However, this did not fully represent that participants responses to boundaries. Therefore, I attempted to uncover the other types of response that may exist in the participants' interviews. Using Nathanson's Compass of Shame model as a base I started to explore what other types of response I could identify in the participants interviews. One way I looked at doing this was to look at what the opposite response would be to each of the points on Nathanson's model and ascertain if these were evident in the participants' accounts. This resulted in a further three responses: Engage; Challenge; and Protect-Other. The elements of these and evidence for them are discussed in the next section. The eighth response Protect-Self was initially not included as I felt that this had already been covered in Nathanson's 4 original responses. However, as I began to systematically consider each boundary response and use examples from the accounts it was clear that there was a distinct response that was Protect-Self. In addition, the responses to shame listed in Nathanson's model were also adapted and changed. The titles of the response were kept the same. However, the actual responses from participants' were distinctly different from Nathanson's model and had different characteristics.