DECLARATION FOR MAJOR RESEARCH PROJECT

Alexandra Bone BSc (Hons)

Factors relating to boundaries and self-disclosure within mental health contexts

Section A:

Understanding the Use of Therapist Self-Disclosure within a Cross-Cultural Context:

A Systematic Literature Review

Word Count: 8,000 (115)

Section B:

"It's a Dent, Not a Break":

An Exploration of How Case-Managers Understand and Navigate Boundaries in Early Intervention in Psychosis Services

Word Count: 8,000 (485)

Overall Word Count: 16,000 (600)

A thesis submitted in partial fulfilment of the requirements of

Canterbury Christ Church University for the degree of

Doctor of Clinical Psychology

Acknowledgments

Thank you to all my participants, who shared their time and valuable expertise with me. I am incredibly grateful to my supervisor, Rachel, for your unwavering encouragement, guidance and support-especially during COVID-19, and even when it was no longer part of your job description! Thank you to my partner, Tom, and to my friends for all your support, and for giving me comfort, laughter and space when I needed them most. Especially thank you to Amy for the "study buddy" weekends! Finally, thank you to my parents, Ros, and Rob, for your unconditional practical and moral support. I could not have done it without you.

Summary of Major Research Project

Section A: Presents a systematic literature review synthesising and critiquing the evidence-base surrounding the use, and impact of therapist self-disclosure in cross-cultural therapy contexts with clients from ethnic minority groups. The review found that as well as mirroring the use and impact of therapist self-disclosure in more generalised therapy contexts, therapist self-disclosure was used to invite conversations about therapists' and clients' cultural or ethnic differences and identities. This included therapists using self-disclosure to validate clients' experiences of racism or oppression and assert their commitment to an anti-racist stance. Risks to therapist self-disclosure within cross-cultural contexts are discussed, and findings and clinical implications are considered in the context of developing therapist cultural competency. The review found that studies had some methodological limitations (such as relying predominantly on self-report methods), and future research should further explore self-disclosure as the mechanism of change, and other possible therapist and client intersecting, or mediating factors.

Section B: Presents a grounded theory study exploring how case-managers in Early Intervention in Psychosis Services (EIPS) develop their understanding and practice around navigating boundaries. EIPS are a unique service model, in which an assertive outreach approach is adopted. Case-managers employ flexible boundaries to meet clients in the community and support them towards recovery and holistic goals. Current boundary theory is therefore not easily applied to this clinical context. Participants were 13 EIPS case-managers. Semi-structured interviews with participants were analysed using grounded theory. A concentric model emerged, defining different layers of influence impacting case-managers navigation of boundaries. The model also depicted how case-managers navigated boundaries with clients over time. This model adds to current boundary theory outside of therapy contexts, and can be used as a tool in clinical practice to guide clinicians' thinking and reflection around boundaries within EIPS. Other relevant clinical and research implications are discussed.

Contents

List of tables and figures

Section C: Appendices

Section A: Literature Review

Understanding the Use of Therapist Self-Disclosure within a Cross-Cultural Context: A Systematic Literature Review

Overall Word Count: 8000

Abstract

Theory and research around therapist self-disclosure (TSD) suggests that, when used judiciously, it can have a number of therapeutic benefits. These include conveying therapist authenticity, normalising experiences, lessening power imbalances, and improving trust, thus strengthening the therapeutic alliance. However, whether these therapy outcomes translate to cross-cultural therapy relationships has not yet been reviewed. This review aimed to synthesise and critique the evidence-base surrounding the use, and impact of TSD in cross-cultural therapy contexts. A literature review was completed in March 2021 across four electronic databases. Two hundred and twenty-six studies were screened according to inclusion criteria, and nine studies of a mixture of methodologies were included in this review. Studies were summarised, findings outlined, and quality of studies critically evaluated. The review found that as well as mirroring the use and impact of TSD in more generalised therapy contexts, TSD was used to invite conversations about therapists' and clients' cultural or ethnic differences and identities. This included using TSD to validate clients' experiences of racism or oppression and assert their commitment to an anti-racist stance. Risks to TSD within cross-cultural contexts are discussed, and findings and clinical implications are considered in the context of developing therapist cultural competency.

Studies had some methodological limitations, such as relying predominantly on self-report methods, and in some studies whether TSD was the mechanism of change, or a combination of factors (including empathy) was debatable. Future research should further explore self-disclosure as the mechanism of change, and other possible therapist and client intersecting, or mediating factors.

Keywords: Therapist self-disclosure, cross-cultural therapy, ethnic minority groups, counselling.

Introduction

In this review, I will be examining the literature surrounding the use of Therapist Self-Disclosure (TSD) within cross-cultural therapy contexts (whereby the therapist and client are from different ethnic or cultural backgrounds).

Definition of Therapist Self-Disclosure

Numerous theorists have offered definitions of TSD (Hill et al., 1989; Jourard, 1971; Zur, 2007). The common defining feature is that TSD occurs when a therapist verbally reveals some form of personal information about themselves. Hill and Knox (2002) (prolific researchers in this area) proposed seven subcategories, which are widely cited in literature. These are outlined in table 1.

Table 1

Subcategories of therapist self-disclosure

Subcategory	Example
1. Biographical "facts"- relating to the therapist's life and professional training	"I studied counselling psychology, and the main model I work in is Compassion Focused Therapy"
2. Feelings-including the use of emotional terms in the therapist's description of their subjective experience	"When my mother does that, I feel angry" "When I have been in situations similar to yours, I felt scared, because I didn't know how things would turn out for me"
3. Insights-into past experiences exemplifying what the therapist has learnt about themselves	"When I was having a similar conflict with a male colleague, I realized that I shut down because I was afraid that he would reject me"
4. Strategies-that the therapist has found effective in dealing with particular issues or problems	"When I faced circumstances like yours, it helped me to gather as much information as I could so that I would be prepared for what might happen"
5. Reassurance/support- legitimization of the client in the specific therapeutic context.	"I can understand your anxiety, I also have a hard time whenever I have to give a talk"
6. Challenges- to the client's thought process or behaviour via examples from the therapist's life.	"I don't know if you are aware that I, too, am divorced, and have had to think hard about my own contributions to the failure of the marriage"

7. Immediacy-disclosing thoughts or feelings which the therapist has towards the client, or about the therapeutic relationship/ process. *Also known as "self-involving disclosures"* (As opposed to non-immediate: disclosing personal information not directly pertaining to the therapeutic relationship/process)	"As you describe the cold relationships in your family now, I am aware that I am feeling very distant and closed off from you. I wonder if that is similar to how you felt with your family?"

Another form of TSD is unavoidable or inadvertent self-disclosures (SD) (Zur, 2007). This is commonly thought of in relation to therapists' personal appearance (e.g., skin colour, accent, wedding ring), of which skin colour and accent are particularly relevant to this review. However, inadvertent TSD can include other factors, such as nonverbal behaviours, or background décor (Zur, 2007). TSD has also been classified by the intimacy of the SD (Hill & Knox, 2002).

Use of TSD

Historically, the use of TSD was hotly debated, and attitude towards TSD was heavily influenced by therapy orientation (Dixon et al., 2001). For example, psychodynamic psychotherapists and psychoanalysts traditionally believed TSD should not occur; therapists should be "opaque to his patients…show them nothing but what is shown to him" (Freud, 1912/1958, p. 118). Therapists' neutrality was believed essential, and TSD would hinder the process of uncovering and resolving client transference (Jackson, 1990).

In the 1950s, therapists from humanistic and existential orientations supported the use of TSD to "demystify" psychotherapy, and promote therapist authenticity and genuineness (Jourard, 1971; Rogers, 1957). Over time, these ideas gained traction, and empirical research has since demonstrated the therapeutic benefits of TSD, with a recent systematic review concluding "self-disclosing therapists elicited more positive responses and perceptions from clients than therapists who did not disclose" (Henretty & Levitt, 2010, p.69). The systematic review demonstrated that TSD is a powerful skill, which can, when used judiciously, strengthen the therapeutic alliance, and

normalise universal human experiences (Henretty & Levitt, 2010). Research has demonstrated it can enhance client trust and engagement in therapy, and lessen the client-therapist power imbalance (Audet & Everall, 2010). These functions of self-disclosure in strengthening the therapeutic alliance are important to examine, given that a wealth of theory and research indicates that the strength of the therapeutic relationship is one of the most important predictors of therapy outcomes, and a key mechanism of change (Norcross, 2010).

However, there are risks with TSD. These include blurred client-therapist boundaries, and gain, or loss, of therapist credibility (Audet, 2011). The literature also warns that the degree of intimacy in TSD "must be carefully calibrated" (Knox & Hill, 2003, p.534). TSDs which are too superficial, or too intimate, could detrimentally impact the therapeutic relationship. TSDs of moderate intimacy may be most effective (Geller & Farber, 1997; Henretty & Levitt, 2010). Whilst TSD can be a means to normalise clients' struggles, it can also minimise a client's unique experience, if not done sensitively (Roberts, 2005). To mitigate these risks, Knox and Hill (2003) set out suggested practice guidelines for using TSD (table 2), for which there is general consensus in the literature (Gibson, 2012).

Table 2

Knox and Hill's (2003) Practice guidelines for using therapist self-disclosure

Suggestions for using Therapist Self-Disclosure
Use therapist self-disclosure because it is a helpful intervention, but use it infrequently and judiciously
Use appropriate content in therapist self-disclosures
Use appropriate levels of intimacy in therapist self-disclosures
Fit the disclosure to the particular client's needs and preferences
Have appropriate reasons for self-disclosing
Return the focus to the client after therapist self-disclosure

Consider using disclosures of immediacy

Consider using disclosures to facilitate termination

Ask clients about their responses to therapist self-disclosure

Self-disclose about issues that you have mostly resolved, rather than those with which you continue to struggle

---

Consistent with this evidence, a plethora of therapy models purport the potential benefits of TSD when used carefully, including humanistic, existential, feminist and systemic therapies, and cognitive behavioural therapy (Mahalik et al., 2000; White, 2007; Ziv-Beiman, 2013). Even within contemporary psychodynamic or psychoanalytic therapy, inadvertent or intentional TSD is now viewed as therapists' subjectivity working at the forefront in therapy, and various proposals have been raised regarding the optimal use of the therapist's disclosure of countertransference experiences, and TSD around facts, experiences, and insights (Bridges, 2001; Hanly, 1998).

Moreover, considering the variation in TSD, including inadvertent or unavoidable SDs; there is recognition that avoiding all forms of TSD is almost impossible (Zur, 2007) and research indicates that 90% of therapists report using some form of TSD (Henretty & Levitt, 2010). Given its prevalence as a therapeutic intervention, it is worth considering whether TSD is as effective with all clients, or whether there are client/therapist individual differences which impact its use or effectiveness. Henretty and Levitt's review (2010) examined a range of client and therapist demographic factors, such as client diagnosis, gender, age, ethnicity, sexual orientation. One tentative finding relating to demographic characteristics was regarding race, ethnicity, or cultural differences between the therapist and client (Henretty & Levitt, 2010). Studies encompassed a range of different client-therapist cross-cultural interactions, and although sample sizes were small, results indicated that client/therapist REC appears to interact with the use and effectiveness of TSD.

An overview of the context and therapy literature surrounding cross-cultural therapy interactions is therefore relevant to examine this further.

Experiences of Therapy for Ethnic Minority Groups

This review will use the term "Ethnic Minority" (EM), as this is the term most recommended, and approved of by people from ethnic minority groups (Race Disparity Unit, 2018). The abbreviation REC (race, ethnicity, or culture/cultural) is also used, as this is broadly cited in the relevant literature (Ballard, 2002).

Many EM groups have experienced prejudice and discrimination in contact with White people at individual, community and institutional levels, and consequently, may be distrustful of future encounters (Centre for Social Justice, 2020; Terrell & Terrell, 1984). Research indicates that these negative experiences extend to accessing health services, with African Caribbean clients in particular reporting higher levels of dissatisfaction with, and mistrust in, health services (Elias & Paradies, 2021; Robinson et al., 2011).

Within a mental health context, research indicates that people from EM groups are more likely to experience mental health difficulties (Bignall et al., 2019). However, in addition to issues with accessibility to services (Memon et al., 2016), studies indicate that clients from EM groups are more likely to drop out of therapy (Kivlighan et al., 2019; Moller et al., 2019). Whilst there could be many factors which contribute to these findings, Kivlighan et al. found that clients' views about their therapists accounted for 14% of variability in EM clients' nonattendance.

Perceptions of therapist cultural insensitivity and racial prejudice can adversely affect EM clients' experiences of therapy (Chang & Yoon, 2011; Constantine, 2007). Studies have demonstrated ways in which therapists may unconsciously, or unintentionally communicate denigrating messages to clients from EM groups. For example, minimising the importance of REC issues, or pathologizing cultural values or communication style (Sue et. al., 2007). Unsurprisingly, one study found that such expressions of covert or unconscious racial microaggressions were predictive of a weaker therapeutic alliance, lower ratings of competence, and therapy satisfaction (Constantine, 2007). A qualitative study examining EM clients' perceptions of the significance of race, found that most clients felt that White therapists could not understand key aspects of their experiences, or were not

attuned to REC differences. Experiences were improved if the therapist was compassionate, accepting, and comfortable discussing REC issues (Chang & Yoon, 2011).

Such findings are echoed elsewhere in the quantitative literature; meta-analyses found that clients matched with therapists of dissimilar REC were more likely to drop out of treatment, and to attend fewer sessions compared to clients whose therapist shared their REC background (although effect sizes are small, indicating ethnic match alone is a weak predictor) (Maramba & Nagayama Hall, 2002; Shin et al., 2005). A similar literature review found that clients from EM groups prefer therapists from a similar REC background to themselves, and this increases comfort level for both parties, even if it does not have a significant impact upon therapy outcomes (Karlsson, 2005).

Therein lies the conundrum; the psychology professions workforce in the UK is mostly Caucasian (Health and Social Care Information Centre, 2013), and unrepresentative of the UK population, of which EM groups comprise at least 14% (Office for National Statistics, 2017). This reveals a wider issue regarding widening access and increasing diversity into the psychological professions (York, 2020), and initiatives are underway to increase the diversity of the psychology workforce (King et al., 2013). However, the question remains as to how therapists can work sensitively to build trust, and increase levels of engagement, comfort and cultural competence when working cross-culturally.

Therapist Cultural Competence

Research indicates it is critical to clients from EM groups that therapists (particularly White therapists) acknowledge and discuss REC similarities and differences (Davis et al., 2018; Thompson & Jenal, 1994). To address this, Owen (2011, 2017) proposed the MCO (Multi-Cultural Orientation) Framework. This theory, outlined in Figure 1, consists of three dimensions to guide therapists in developing cultural competence. Therapist multicultural competencies (MCC) refers to therapists' knowledge, skills, and awareness when working with clients with REC differences (Sue & Sue, 2003).

Figure 1

Multicultural Orientation Framework

Given that research has indicated that the way in which therapists approach or avoid conversations or SD around race can help or hinder client affiliation respectively (Chang & Berk, 2009; Thompson et al., 1994), the MCO framework could therefore be relevant when considering TSD.

TSD Within Cross-cultural Contexts

There was a brief surge of analogue studies (simulated therapy interactions) in the USA in the 1980s and 90s, examining the impact of TSD within cross-cultural therapist-client relationships. Studies found that African American participants trusted, and self-disclosed more with African-American therapists. With a White therapist, consistent with general TSD literature, participants had less favourable impressions, and self-disclosed less if the therapist provided superficial SD compared to more intimate SD (Berg & Wright-Buckley, 1988; Wetzel & Wright-Buckley, 1988). A more recent

analogue study found that African American clients had a higher preference for TSD than White clients (Cashwell et al., 2003). Other studies involving Latin-American participants found that they expected less TSD than White participants, rating therapists as more trustworthy and expert (and were more willing to SD) when they summarised back, rather than self-disclosed (Cherbosque, 1987). These findings suggest that there are differences between ethnic groups in how TSD is perceived and valued.

Although these studies are a useful starting point, they significantly lacked ecological validity. They were all analogue studies, which used undergraduate students as "clients", and the majority also used undergraduate students or confederates to play the therapist role. The "therapy" intervention either consisted of a short, simulated therapy session, or involved participants imagining a therapy session and their ideal therapist.

Since then, more theory and ecologically valid research regarding TSD within cross-cultural therapy contexts has arisen. Theory suggests that TSD could be an important intervention to demonstrate therapists' sensitivity and ability to acknowledge and appreciate REC differences and similarities. TSD could also be used to convey recognition of clients' experiences with oppression and racism, resulting in increased trust, greater perception of therapist credibility, and an improved therapeutic relationship (Constantine & Kwong-Liem, 2003; Helms & Cook, 1999).

TSD could potentially be a skill used within the MCO framework, as a way for therapists to build trust, create opportunities with clients to discuss their cultural identities or REC difference using a humble, open and curious stance (Owen et al., 2016), and increase levels of comfort for both therapist and clients from EM groups; who, historically, have been more likely to drop out of therapy.

Rationale and Aims for this Review

Whilst a more recent, ecologically valid evidence-base now exists investigating the use of TSD within cross-cultural therapy contexts, this research has not yet been collated or systematically

reviewed. The purpose of this systematic literature review is therefore to synthesise and critique the more recently published empirical literature, to ascertain what we can understand about the use and therapeutic impact of this skill within cross-cultural therapy contexts. The review will explore how this can be applied to current theory, and implications for clinical practice and future research. This review aims to answer the following questions:

a) How is TSD being used within cross-cultural therapy contexts?

b) What is the impact of TSD within cross-cultural therapy contexts?

Method

Search Strategy

A systematic literature search was conducted in March 2021 within four databases: Psycinfo, Web of Science, Pubmed, Applied Social Sciences Index and Abstracts (ASSIA). The search terms used were: (Therap* OR Counsel* OR psychologist) AND (cross-cultural OR cross-racial OR Rac* OR Cultur* OR ethnicity) AND (self-disclos*)-applied to titles and abstracts. A restriction date of the year 2000 was applied, given the review aims to review more recent research. The references of identified studies were hand searched for further relevant papers, and a Google Scholar search was conducted to check for grey literature, or any relevant studies which the search terms had not captured on the databases.

The inclusion criteria outlined in table 3 was used to identify and screen 226 studies through their titles, abstracts or full texts. Given the issues of ecological validity with some studies in this area of research, an exclusion criterion was added whereby analogue studies were only included if a therapist (either qualified or in professional training) was employed within what could be deemed as a realistic therapy context.

A PRISMA diagram (Moher et al., 2009) in figure 2 depicts the systematic literature search process, and the resulting nine studies included in this review.

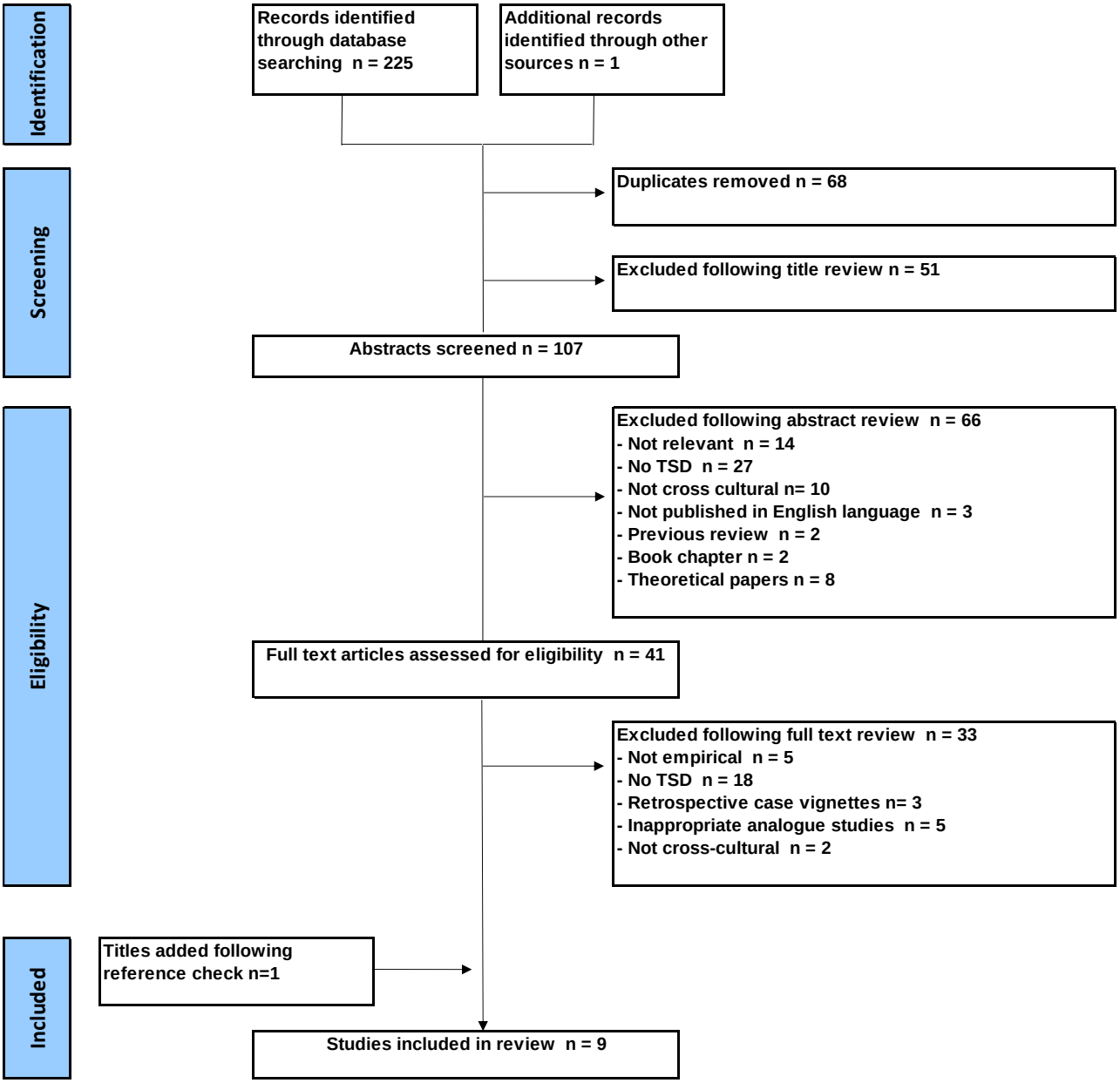
Table 3

Inclusion and exclusion criteria for studies

Inclusion Criteria	Exclusion Criteria
• Published in the English language • Published in a peer-reviewed journal • Empirical studies where a key element of the study focuses on therapist self-disclosure in a cross-cultural context between therapist and client • Therapist/counsellor/psychologist is qualified or in professional training	• Not empirical research (e.g., discussion papers, book chapters, informal case illustrations or vignettes) • Empirical studies examining cross-cultural therapy relationships, but where therapist self-disclosure is not a key element. • Analogue studies in which the therapist is not qualified or in professional training, and a realistic therapy intervention is not undertaken

Figure 2

PRISMA diagram



Structure of Review

The nine studies appropriate to review are summarised in table 4. It was deemed that all studies were conducted to a relatively high methodological standard. Therefore, findings are presented first, broken down into themes, followed by a critical appraisal of the quality of the studies. The research is then discussed considering methodological considerations, and implications

for theory, clinical practice and future research. Limitations of this review are acknowledged, and conclusions made.

Review

Table 4

Summary of study characteristics and findings

Study (in alphabetical order)	Aim	Design and setting	Sample	Measures and analysis	Key findings
1. Bitar et al. (2014)	To explore the use of TSD in a cross-cultural therapy context with Mexican-American male clients in court-mandated therapy	Qualitative-phenomenological methodology Court mandated therapy in the community in the USA	10 adult males who identified as Mexican-American, currently undertaking psychotherapy in the community and on probation for a federal offense. Recruited through community mental health agencies	Interview guide-two in-depth interviews conducted with each participant. Analysed using a descriptive phenomenological approach.	Four main themes emerged. TSD: • helped to build the therapeutic relationship • normalized client struggles • lessened the therapist-client hierarchy • modelled the acceptability of SD These themes linked to societal norms within Latino culture.
2. Burkard et al. (2006)	To examine therapists' use and effect of TSD with clients within cross-cultural therapy contexts.	Qualitative-Consensual Qualitative Research (CQR). Interviewing therapists/ psychologists in the USA	11 White therapists (5 male, 6 female) with experience of delivering therapy with clients with REC differences. Recruited through email mailing lists and snowballing technique	Semi-structured interview protocol. Interview and brief follow-up interview conducted with each participant. Analysed using CQR.	• TSD was often used when clients were talking about racism or oppression, or when participants were concerned clients viewed them as being complicit in racism. Instances of TSD around issues unrelated to race also occurred. • Reasons for using TSD included to: enhance/preserve the counselling relationship, acknowledge the role of racism within the client's life or therapists own racist/oppressive beliefs, share own cultural values/beliefs and acknowledge differences. • TSD had a positive effect-improved trust and mutual respect, normalised clients' experiences, allowed clients to self-disclose more.
3. Chang and Berk (2009)	To explore racial/ethnic minority clients' experiences of cross-racial	Qualitative-phenomenological / CQR	16 adult participants from EM groups with experience of satisfying or	• Semi-structured interview schedule. Interview and follow-up interview (where	• TSD was a discriminating feature associated with treatment satisfaction. • 7/8 satisfied clients reported TSD, compared to 2/8 of unsatisfied clients.

	therapy. To Identify therapeutic elements which influenced satisfaction of therapy experience	Interviewing clients who had experiences of receiving therapy in the USA	unsatisfying cross-racial therapy with a White therapist. Recruited through multilingual public advertisements	possible) conducted with each participant. Analysed using CQR.	• 3 clients wished for more TSD • Half of TSD related to REC issues (e.g., therapist REC identity, experiences of discrimination or oppression), half involved disclosures of personal history (e.g., marital/parental status, personal experiences of similar problems). • Satisfied clients reported TSD enhanced the relationship. The 2 unsatisfied clients reported TSD only served to emphasise the social and cultural distance between them, or was done too early in the therapeutic relationship. • Cultural competence was positively associated with therapeutic alliance, cultural incompetence was negatively associated with therapeutic alliance
4. Kim et al. (2003)	To examine how Asian-American clients of differing cultural values experienced different types of TSD in a therapy sessio with European-American therapists	Quantitative-Experimental, between-groups, with collection of quantitative, and observational data Participants undertook a one-off therapy session in which they discussed personal real-life problems with a therapist, who implemented either a high or low TSD. (Low TSD=none, unless a significant clinical need for TSD arose during the session.) Each therapist	62 Asian-American university students recruited through the university 17 European-American trainee therapists-15 were doctorate students in clinical or counselling psychology. 2 were masters students in pastoral student counselling. Recruited through their respective training programmes	•Sessions were observed by researchers through a one-way mirror and the TSD and type recorded. After the session clients (and therapists after high TSD) completed: • TSD manipulation check • The Helpfulness scale (assessing helpfulness of TSD) • Intimacy of TSD • Clients also completed a range of other scales assessing their perception of the	• Asian American participants of differing cultural values did not rate helpfulness of TSD differently. • Presence or absence of TSD was not related to session outcome. • TSD of approval/reassurance or of strategies were used most frequently by therapists. Participants rated strategy TSD's as most helpful. • Intimacy of TSD was related to perceived helpfulness of TSD -Both clients and therapists rated TSD as more helpful when they also perceived them as being more intimate (most TSD were within the moderately intimate range) • Therapists and client's perception of intimacy was related to one another, suggesting therapists are able to determine how intimate clients may perceive a TSD to be.

		conducted an equal amount of high or low TSD sessions.		therapist and the relationship. • Quantitative data analysed using inferential statistics: t-tests, MANOVA, ANOVA.	
5. Lee (2014)		Qualitative-critical discourse analysis The first 3 therapy sessions from each therapy dyad were recorded and transcribed. Paper presents two case vignettes from two of the therapy dyads.	6 cross-cultural therapy dyads: 4 White female psychologists/social workers who also had a therapy qualification. 6 adult clients from diverse EM groups. Therapists and clients were recruited from a mental health agency in Canada.	• Transcribed sessions were analysed using critical discourse analysis.	• TSD of professional or cultural values often became the implicit but universal norm that questioned their clients' values as deviant, and positioned the culturally different clients as "a subordinate other". • TSD of professional, or cultural beliefs produced therapeutic interactions that either permitted or limited their topics/ focus by alluding to what was relevant or valued in therapy. • TSD in both cases led the clients to disengage or withdraw from treatment plans that diverged from the clients' subjective experiences of cultural norms and expectations.
6. Maxie et al. (2006)	To examine therapist's attitudes and practices around discussing REC in across-cultural therapy context, and examine therapist characteristics as potential moderators of these practices	Mixed methods- Quantitative and qualitative data collated via a survey APA registered psychologists in the USA	689 APA registered psychologists in the USA with experience working with clients in a cross-cultural context. Recruited through APA mailing lists 93.3% of psychologists were White, 6.7% from EM groups. 52.4% female, 47.6% male	• Survey through which qualitative and quantitative data was gathered • Qualitative data analysed using Narrative Analysis. • Quantitative data analysed using descriptive statistics, correlations, multiple regression and an ANOVA	• TSD used in the context of explicitly acknowledging differences with clients. Used to: -convey appropriateness of discussing differences. -determine if the client views difference as a problem in therapy. -communicate possible limitations of therapist's cultural understanding, express interest in understanding issues from client's perspective and promote collaboration. • Therapists used humour with TSD to facilitate conversations about REC differences. • Therapist experiences and comfort influenced ability to use TSD and address differences. -Positive influences- e.g., having experience of living in diverse communities, having political awareness/being involved in activism.

					-Negative influences-e.g., having had a negative experience using TSD, worries about making inappropriate statements
7.	Phiri et al. (2019)	To explore the views on client initiated TSD within cross-cultural therapy contexts from a range of EM clients and lay people, and therapists and MH practitioners	Qualitative-ethnographic focus EM clients and community members, and therapists and MH practitioners in south of England	Total sample size: 114 EM clients (n=15) from either African Caribbean or South-Asian ethnic groups. MH practitioners (n=25) CBT therapists (N=22) all recruited through NHS mental health services. Clients all had a diagnosis of a psychotic disorder. Community members (n=52) recruited through local EM community links.	• Semi-structured interview schedule-semi-structured individual interviews with clients. • Focus groups with MH practitioners, CBT therapists, and lay members. • A total of 38 interviews or focus groups were conducted. • Focus groups and interviews were transcribed and analysed using thematic content analysis	• For clients, TSD signified they were being treated as a human being. The client is judging and using TSD as a vehicle to establishing rapport • Mistrust, and a sense of "them and us" was greater for African Caribbean client group. Fear of being misunderstood and misinterpreted. • Clients would "test" therapists with requests for TSD and "tricky questions" to assess trustworthiness. How therapists responded was more important than the content: -If therapist responded with a SD, client felt they were trustworthy and disclosed more themselves. -If they declined to answer/were defensive, the client disclosed less, and was less responsive in therapy. • Therapists reported experience and comfort using TSD was a key factor with African Caribbean clients. The more comfortable and willing to SD a therapist was, the better the client engaged in therapy. • For community members, TSD around religious beliefs, age, marital status, children was important
8.	Sunderani and Moodley (2020)	To examine therapists' perceptions of their use (or refraining from use) of TSD during cross-cultural exchanges.	Qualitative-grounded theory Therapists working in Canada	9 therapists-6 female, 3 male. 8/9 therapists were White. Recruited through Psychology Today-online website/mailing lists	• Semi-structured interview guide • Individual, semi-structured interviews • Analysed using grounded theory-constant comparison method	2 major themes emerged: • 1: Contexts when therapists self-disclose -client curiosity -shared difficult/traumatic experiences -cultural similarities • 2: Contexts when therapists refrain from TSD: -boundary issues -awareness of overidentification -Cultural differences (Be careful when disclosing with someone culturally different to them, unfamiliarity with other cultural values

					and norms, fears of violations/being perceived as disrespectful/imposing their values onto clients)
9. Twohey & Lokken (2004)	To examine cross-cultural dynamics between euro-American therapists and American-Indian Clients, and determine facilitative or inhibitive counselling interventions	Qualitative-grounded theory Participants undertook a one-off therapy session in which they discussed personal real-life problems with a therapist	13-18 American Indian participants-recruited through 2 communities in northern USA 8 females and 5 males 7 European-American trainee clinical or counselling psychologists recruited through doctoral training programmes	• Sessions were videotaped • Following the session, participants were interviewed using the Interpersonal Process Recall method. • Therapy sessions and IPR interviews were analysed using grounded theory	• TSD was identified as a key counselling intervention which made participants feel more comfortable and connected to the therapist • TSD helped to: -build trust, (e.g., the SD showed participants that the therapist trusted them) -give the therapist credibility -aided participants in deciding how much to self-disclose themselves • Often TSD was used to demonstrate common ground between the therapist and the participant

Note. TSD=Therapist Self-Disclosure. SD= Self-Disclosure. EM= Ethnic Minority REC= racial, ethnic and/or cultural. CQR=Consensual Qualitative Research. MH=Mental Health

Overview of Studies

All studies were conducted in North America, apart from one UK study. Concerning study design, seven studies were qualitative, one was quantitative, and one was mixed methods. Table 5 outlines the composition of participants in each study.

Table 5

Composition of participants per study

Participants	Study
"professionals": qualified psychologists or therapists	Burkard et al. (2006) Maxie et al. (2006) Sunderani & Moodley (2020)
Therapy clients	Bitar et al. (2014) Chang and Berk (2009)
Mixed sample (of professionals/professionals in training and clients)	Kim et al. (2003) Lee (2014) Phiri et al. (2019) Twohey and Lokken (2004)

In two of these mixed sample studies, "clients" had not undertaken therapy, but were instead people who participated in a one-off therapy session. However, the sessions were conducted as a realistic therapy session, and participants were asked to talk about a real-life problem. Given the descriptions of participants' problems, and the "real-life" nature of this intervention, these studies were deemed ecologically valid, and worthy of including. As the majority of studies were conducted

in North America, the term “counsellor” is often used, although examination of therapists’ credentials in these studies confirmed they were mostly clinical or counselling psychologists.

All participants were adults. Sample sizes ranged between 9-689 (most studies had sample sizes below 100). Clients in studies were from a range of ethnicities; African Caribbean, African-American or Black-British, South-Asian or Asian-American, American-Indian, and Mexican. The majority of professionals were White.

Collated Findings

Findings are grouped based on pertinent themes. Appendix 1 contains examples of how TSD was used in relation to REC (and several other themes).

How TSD is Defined and Recorded

All studies, except Lee and Maxie et al. had a TSD definition which involved the revelation of personal information by the therapist. Most studies expanded upon this definition with different classifications of TSD, including inadvertent, immediate/self-involving, and intimacy of SD. Maxie et al. examined therapeutic factors in cross-cultural therapy (TSD being a key finding), and thus TSD was not specifically defined beforehand. Lee operated from a constructivist epistemological position, and raised questions about how we currently define SD, arguing that disclosing, or revealing a therapist’s personal self is inseparable from disclosing a professional and/or cultural self. However, in their findings they did refer to known terms in the literature.

Concerning type of TSD recorded, Chang and Berk and Sunderani and Moodley used Knox and Hill’s classification system (2003), and Kim et al. used an earlier version of this system, with five categories (Hill & O’Brien, 1999). Burkard et al. and Twohey & Lokken classified types of TSD using a mixture of known terms (e.g., “self-involving”) and self-defined terms which arose organically through their coding process, often relating to REC, such as “sharing own cultural values”. Kim et al. also measured perceived intimacy of TSD. Bitar et al., Maxie et al., Phiri et al. only classified TSD by

context or influencing factors (e.g., when therapists would or would not SD). Study content broadly fell into three categories, outlined in table 6.

Table 6

Studies depicted by content of TSD

Content of TSD	Study
Use of TSD specifically relating to REC	Burkard et al. (2006) Maxie et al. (2006)
More general use of TSD (within a cross-cultural context)	Bitar et al. (2014) Kim et al. (2003) Lee* (2014) Twohey and Lokken (2004)
Both general and REC specific use of TSD	Chang and Berk (2009) Phiri et al. (2019) Sunderani and Moodley (2020)

* *Lee (2014) used TSD which was indirectly related to REC, but analysed through a REC lens using Critical Discourse Analysis (CDA).*

Impact on the Therapeutic Relationship and Outcomes

A number of client and therapist studies found that TSD impacted upon the therapeutic relationship, and/or therapy outcomes. Most of these studies found TSD had positive impacts: Bitar et al., Burkard et al., Chang and Berk, Maxie et al., Phiri et al., and Twohey and Lokken found that TSD helped build, enhance, or preserve the therapeutic relationship, or improve treatment outcomes. Bitar et al. and Phiri et al. reported TSD signified to clients that they were being treated as human beings; enabling clients to relate to their therapists as people. Therapists in Burkard et al. reported noticing that clients were more visibly relaxed or less hypervigilant after a TSD, or there

was a sense of mutual respect.

Chang and Berk found that TSD was a discriminating feature associated with treatment satisfaction; seven/eight clients from the "satisfied" group reported TSD. These clients reported TSD enhanced the relationship with their therapist. However, Kim et al. found that presence or absence of TSD was not related to client rated session outcome. It is notable that two participants from the "unsatisfied" group in Chang and Berk reported wishing their therapist used SD more, with one participant commenting she had hoped to share an "immigrant connection" with her therapist (who was German), which she felt would have enhanced their therapeutic relationship.

Developing Trust

Several client studies reported mistrusting mental health services, with a sense of "them and us". This sense was particularly strong for African Caribbean and Black-British clients in Chang and Berk and Phiri et al., who feared being misunderstood, or misinterpreted by therapists. Clients in Phiri et al. reported "testing" therapists with tricky questions, and requests for TSD, to assess trustworthiness. If therapists responded with some form of SD, clients felt they were authentic and trustworthy, and would SD more themselves. However, if their therapist declined to answer their question or acted defensively, then clients self-disclosed less themselves, and were less engaged.

This finding was mirrored in Burkard et al. and Twohey and Lokken; therapists reported TSD improved trust and respect, enabling clients to SD more. Participants in Twokey and Lokken reported TSD showed that their therapist trusted them enough to share their own personal information, thereby building trust, and aiding participants to SD themselves. There were similar findings from Bitar et al., whereby clients reported that TSD modelled the acceptability of SD.

Relationship to Comfort

Maxie et al. found that therapists' prior experiences and level of comfort influenced their ability to use TSD to address REC differences. These experiences included having socio-political awareness/being involved to some degree in activism, or having lived in diverse communities.

Experiences that decreased therapists' comfort included worries about making inappropriate statements, or having had previous negative experiences using TSD around REC. Similarly, therapists in Phiri et al. reported that experience with, and comfort in using TSD was a key factor for African Caribbean or Black-British clients. The more comfortable with, and willing to SD a therapist was, the better the client engaged in therapy.

These findings map onto client studies Bitar et al. and Twohey and Lokken. From Bitar et al., most clients described the initial challenges of attending therapy, and the discomfort they felt in being expected to SD to a stranger-particularly a White therapist, who many participants viewed as part of the "establishment". When describing the transition towards greater comfort, clients expressed how critical TSD was in creating a more relaxed and comfortable environment for SD. In Twokey and Lokken clients reported TSD was a key therapeutic intervention which made them feel more comfortable, and connected to their therapist.

Using TSD to have Conversations about REC

For those studies which included TSD around REC, a major use was to invite conversations about race and cultural identities. In Burkard et al., Chang and Berk, and Maxie et al., therapists used TSD to acknowledge and validate clients' experiences of racism or discrimination, and express their emotions. In some cases, therapists chose to do this to assert their position, lest their clients viewed them as complicit in racism or racist systems. Therapists reported the effects of this type of TSD were that clients felt understood or believed, with one client relieved that their therapist did not think they were "making the story up" (Burkard et al., 2006, p. 15).

Another use of TSD around REC in Burkard et al. and Maxie et al. was to acknowledge one's own blind spots, shortcomings, or lack of knowledge regarding REC issues. This was usually done within the context of a good therapeutic relationship, in order to express a strong desire to understand REC issues from the client's perspective, and promote collaborative working in which their REC experiences were valued and incorporated into the work. Therapists in Burkard et al.

reported this type of TSD was well received by clients who respected their honesty and commitment to tackling unconscious bias, which improved the therapeutic relationship. However, as demonstrated by a participant's negative experience in Maxie et al., this type of TSD has a potential risk of "backfiring"; potentially indicating to clients who are already mistrusting, that their fears or suspicions are confirmed.

In Burkard et al. and Maxie et al., TSD was used to share their own cultural values or beliefs, and openly acknowledge similarities or differences between themselves and their clients as an important vehicle to working effectively with clients. This also conveyed the appropriateness or acceptability of discussing differences, or to ascertain whether the client viewed REC difference as a problem in therapy. However, Sunderani and Moodley reported therapists were less likely to SD when there were cultural differences between themselves and their client. They felt unsure how to use TSD with clients from unfamiliar cultural backgrounds, and were wary of being disrespectful of, or violating, different cultures norms or values, or imposing their own cultural values onto the client.

These risks were also found in Chang and Berk and Lee. From Chang and Berk, one of the two "unsatisfied" clients who reported TSD, felt it served only to emphasise the social and cultural distance between him and his therapist. Additionally, Chang and Berk found that client perceived therapist cultural competence positively influenced the therapeutic alliance, whereas perceived cultural incompetence negatively impacted the therapeutic alliance.

Critical discourse analysis (CDA) used by Lee revealed that TSD of their own cultural beliefs or values often became the implicit but universal norm, which questioned clients' culturally different values as "deviant", and positioned them as subordinate to the therapist's own cultural values. TSD of personal or cultural beliefs produced therapeutic interactions which permitted or limited the topics discussed, alluding to what was relevant, or valued in the therapy by the therapist. If this diverged from clients' subjective experiences of their cultural norms and expectations, they disengaged from such conversations. It was also noted that when therapists focused only on the content of the TSD (e.g., disclosing their marriage status in response to a question) as opposed to

also attending to the cultural context surrounding it (e.g., the significance of marriage within someone's culture), opportunities were lost to make different perspectives or discourses meaningful, or to help clients explore their own perspective.

Impact on the Hierarchical Relationship

A number of studies reported that TSD lessened the therapist-client hierarchy. Clients in Bitar et al., Chang and Berk, and Phiri et al. reported TSD made them feel more respected and equal in the relationship. Similarly, clients in Twohey and Lokken reported TSD demonstrated common ground between them. Bitar et al. and Burkard et al. also reported TSD normalised clients' experiences and softened feelings of shame, which clients valued. However, Lee warns that TSD of personal or cultural beliefs can subtly reinstate/underline the hierarchical imbalance, by producing therapeutic interactions in which the therapist either permitted or limited conversations around REC, and decided whose, or which cultural norms or values took precedence.

Importance of When and How TSD is Used

Therapists in Maxie et al., Phiri et al., and Sunderani and Moodley reported that deciding whether to use TSD was dependent on multiple factors, including presenting problems, client individual characteristics, and the idiosyncratic therapeutic relationship. In line with Knox and Hill's practice guidelines (2003), most studies either specified or reported that the use of TSD was brief, fitted the client's needs, and that focus was returned to the client in a timely manner following the TSD.

Chang and Berk and Maxie et al. referenced the importance of timing; deciding at what point to use TSD within the therapeutic relationship. In Maxie et al. there was a range of views regarding the best time to address REC differences. Some therapists used TSD relating to differences between themselves and the client in the initial session, within the context of exploring how it felt for clients to be meeting with somebody from a different REC to themselves. Some therapists used humour to facilitate these conversations. Other therapists described waiting until the relationship

was further developed, which also gave opportunity for clients to initiate such discussions. This finding was supported by the second "unsatisfied" client in Chang and Berk, who felt that TSD was done too soon into the therapeutic relationship, before they were "on that level" (Chang & Berk, 2009, p.11).

Kim et al. examined the intimacy of the TSD as a moderating factor. Both clients and therapists rated the TSD as more helpful when it was perceived as more intimate. This should be caveated by stating most TSDs were rated within the "moderately intimate" range, suggesting therapists did not stray into too intimate territory, which may have had an adverse effect (Henretty & Levitt, 2010). Findings from Bitar et al. could link to this; they reported TSD was most successful when clients perceived TSD as an expression of authenticity and genuineness; a natural part of connecting as opposed to a forced or scripted intervention.

Regarding making decisions about use of TSD; participants in Phiri et al. and Sunderani and Moodley cited client curiosity as a major context in which they would SD. For clients in Phiri et al., how therapists responded to such requests was as, if not more, important, than the content of the TSD for clients.

Another context for using TSD in Sunderani and Moodley was if therapists had shared a similar difficult life experience as their client. These were often historical, and TSD involved emphasis on how they had accepted or overcome such difficulties. However, TSD sometimes encompassed current struggles (e.g., difficulties with parenting), used to normalise client's experiences. Therapists reported TSD around shared experiences was an important way of connecting with clients from different REC, and illuminating common ground. They felt this was often a profound moment in the therapy process.

A context in which TSD was not used in Sunderani and Moodley was when therapists had concerns around boundary transgressions. Some therapists would decline to answer personal questions, believing it infringed upon the client/therapist boundary. For these therapists, protecting and maintaining a strong boundary was of high importance. A final salient context in which TSD was

not used in Sunderani and Moodley and Burkard et al. was when therapists were aware of overidentifying with their client. If clients were too reminiscent of themselves, or therapists felt triggered by their clients in some way (including aspects relating to cultural beliefs or background), they tended not to use TSD for fear of inappropriate or unhelpful countertransference. Similarly, they refrained from using TSD if they suspected it would elicit a negative reaction from the client, and were cognisant of potential detrimental effects (e.g., discomfort, guilt).

Differences Between Cultures

Whilst the study set is not large enough to make firm conclusions regarding preferences in use of TSD between EM groups (as there are not enough studies of any one group), some tentative findings can be drawn.

Asian-American participants in Kim et al. rated, and commented on TSD of strategies as most helpful. These findings should be interpreted cautiously, as they are based on a single therapy session. By contrast, in Bitar et al. Mexican-American clients valued TSD most for its opportunities to build connections with their therapist and get to know them on an equal, and more personal level; "humanising" the therapist. In Burkard et al., Phiri et al., and Twohey and Lokken, with American-Indian, African-Caribbean and Black-British clients, the most prominent facet of TSD was its function in testing, and developing trust with their therapist, although feeling respected and equal in the relationship were also important functions.

Critique

This section involves an evaluation of the quality of the studies reviewed. This was aided by using a quality appraisal tool; the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018), as seen in appendix 2. The MMAT was chosen because it is designed specifically for use in systematic reviews involving studies with a range of methodologies.

Study Design and Methods

Studies included genuine clients who had received/were receiving therapy, or, in Kim et al., and Twohey and Lokken, involved a realistic therapy session, in which clients spoke about real-life problems. Therefore, ecological validity was high in all studies.

Most studies implemented their respective methodologies to a high standard. In the qualitative methodologies employed in all studies except Lee, a number of quality assurance measures were put in place to minimise researcher-bias, such as bracketing interviews (Tufford & Newman, 2012), process notes or research/reflective diaries, independent reviewers or peer debriefing, and respondent validation (Lincoln & Guba, 1985). Kim et al., Phiri et al., and Twohey and Lokken also made efforts to ensure that data analysers included researchers or reviewers from similar REC backgrounds to their participants. In Burkard et al., Chang and Berk, and Kim et al. interviewers (and therapists where relevant) were well trained in interviewing (or use of TSD for therapists), and pilot, or practice interviews/sessions were conducted. Such measures enhance credibility of findings, although in some cases limited information regarding these processes were included.

A critique of Bitar et al. was that the researcher also worked as a therapist at the site where he recruited clients. He did not interview any of his own clients, but acknowledged potential bias on the part of participants (refraining from giving negative feedback due to an awareness of the researcher's position). There was also little comment regarding researcher reflexivity; how the researcher's own relationship to this service may have influenced their analysis, and how this was mitigated with the use of peer debriefing.

Lee had some complex flaws in the conduction of their analysis. They included no independent reviewer, peer debriefing process or respondent validation, and made no comment around potential researcher-bias. Within CDA, such processes would not generally be recommended (having independent reviewers or multiple coders for example, is criticised in DA because you may both be steeped in the same discourses (Parker, 1992)). However, CDA does advise researchers to consider their positioning, and the discourses which may have affected their own worldview when

approaching the analysis (Parker, 1992), which was absent from this study.

Their findings were striking in comparison to the other studies as they primarily emphasised the pitfalls and dangers of TSD. This is a valuable contribution to the evidence-base, although their findings are slightly diminished by a lack of acknowledgement of the researcher's own positioning, which could have increased the validity of such interpretations. Moreover, extracts from only two of the six client-therapist dyads are included to demonstrate their analysis, and there is no comment as to whether similar or divergent patterns or discourses emerged from the remaining therapy dyads. Presumably these cases were chosen because they best highlighted the risks identified, however, this creates the impression of only receiving partial findings, and it is difficult to know whether such problematic interactions were representative of all therapy dyads.

Most studies measured use and impact of TSD through interviews or self-report measures. Findings from studies in which participants were only therapists (see table 5) are disadvantaged, because we cannot guarantee they accurately judged the impact that TSD had on their clients. Research indicates that therapists are often not fully aware of client reactions (particularly negative reactions), in fact, therapists and clients frequently differ in their views of how the therapy is progressing (Hannan et al., 2005; Hill et al., 1993). Therapists in Maxie et al., provided little information as to how they defined successful treatment (although a few pointed to re-referrals from prior cross-cultural clients requesting further therapy). Self-report measures and interviews also include the risk of a social desirability bias, therapists over/underestimating their competencies, or being unaware of blind spots. However, the survey design in Maxie et al. did allow for an extremely large sample size of therapists, enhancing generalisability of findings.

Similar flaws were present in client studies. It was noted that clients in Bitar et al. reported no negative experiences with TSD. Given that this sample were clients receiving court-mandated treatment, and possibly knew the researcher's position, there may have been a greater social desirability bias, or fear of reporting negative outcomes. Satisfied clients in Chang and Berk identified TSD as a common element associated with client treatment satisfaction, amongst other

relationship variables. However, longitudinal, mixed-methods research would be required to confirm these associations.

By contrast Kim et al. and Twohey and Lokken collected multiple forms of data to corroborate findings which reduced the risk of self-report bias; observing or recording therapy sessions alongside conducting interviews or administering valid and reliable self-report measures (in the case of Kim et al.). A limitation of both studies is that they were based on a "one-off" session of therapy. It could be argued that the effects of TSD can be more easily discerned in this context, as there are fewer confounding variables (such as the history of the therapeutic relationship). However, it could be difficult to extrapolate these findings to a more longstanding therapy relationship, as different TSDs may have differential effects on the client at different stages of the therapy relationship. For example, in Kim et al., clients rated TSD of strategies as most helpful. It may be the case that this form of TSD is facilitative in "hooking" the client into the therapeutic relationship during the early stages, however in later stages of therapy the same form of TSD could potentially be perceived as unhelpful, reinforcing the power imbalance. This could particularly be the case if a client's attempts to implement recommended strategies were unsuccessful.

TSD as the Mechanism of Change

In several studies, it was questionable whether TSD was the mechanism of change producing favourable outcomes. In Burkard et al., and Chang and Berk for example, TSD often centred around therapists acknowledging and validating clients' experiences of racism or oppression; using TSD to convey their beliefs or experiences, or assert a personal anti-racism stance. Such use of TSD involves demonstrating empathy (an important factor in psychotherapy effectiveness (Elliot et al., 2011)), and it could be argued it is difficult to disentangle these concepts. This leads us to question whether it is the TSD per se which creates the positive effects reported, or whether it could in fact, be other factors, such as demonstrating empathy, or a combination of factors.

Client and Therapist Mediating Factors

There were a number of additional therapist or client potential mediating factors which most studies did not examine.

Regarding therapist mediating factors, a possible factor could have been the therapy model used. Therapists across most studies were from a range of therapy orientations, but Chang and Berk, Lee, and Twohey and Lokken made no comment about therapist orientation/training. Burkard et al. asked participants how much training they had received in using TSD, but did not investigate the impact that their therapy model had on use of TSD. Only Maxie et al. investigated theoretical orientation as a factor impacting use of TSD, finding no significant differences regarding comfort, skill, or utility of TSD about REC. However, on a more general measure of discussions about REC differences within therapy, CBT and "eclectic" therapists had fewer discussions than other therapy orientations (psychoanalytic, psychodynamic, humanistic, integrative). A flaw of this study was that no description of therapists describing themselves as "eclectic" was provided. Nonetheless, this finding, in addition to acknowledged differing views about TSD between therapy models, could suggest that the impact of therapy orientation on how TSD is used should be considered.

Whilst all studies involving therapists provided some detail about their level of experience; examining this as a potential mediating factor on use/effectiveness of TSD was only explored in study 6 (which found that age, and more experience with cross-cultural clients was associated with more discussions about differences generally, and was slightly related to greater comfort and perceived skill in use of TSD). Kim et al. and Twohey and Lokken employed trainee clinical or counselling psychologists. Kim et al. employed a manipulation check which confirmed that TSD was undertaken successfully and appropriately, however for both studies whether the level of skill and experience with which this was done (which may differ between trainees and qualified therapists) could have affected outcomes, was not discussed.

Generalisability

The range of participants in studies allowed for some tentative conclusions to be drawn about differing effects and perspectives of TSD between EM groups. However, a critique identified by most studies was that due to generally small and diverse samples, there are likely to be group-specific or dyad specific issues which studies were unable to examine in detail, such as migrant vs first or second-generation clients, or intersectionality; the impact of other intersecting identities of clients and therapists, such as gender, class, sexuality, or religion. Additionally, all studies referred to therapy sessions conducted in English with clients, meaning findings may not be generalisable to a significant proportion of cross-cultural clients: those who require an interpreter in therapy.

Discussion

This review aimed to explore how TSD is being used within cross-cultural therapy contexts, and its impact. A strength of all the studies was high ecological validity, a contrast to early research in this field. However, the literature should be considered in light of the knowledge that most studies (bar two) relied only on self-report measures, and thus are fallible to self-report bias, and, in the case of therapist only studies, the possibility that they may have misjudged the effects of TSD or the quality of the therapeutic relationship.

This literature indicates that TSD is being used in a range of ways, many of which mirror the use and impact of TSD within generalised therapy contexts (Henretty & Levitt, 2010). Firstly, the way in which TSD was used in these studies was largely coherent with Knox and Hill's practice guidelines (2003). Reasons for using TSD included building or improving the therapeutic relationship, lessening the therapist-client hierarchy, and normalising or sharing clients' struggles. Similarly, TSD was not used when there were concerns about boundary transgressions, or overidentifying with clients. TSDs of moderate intimacy were most effective, and those undertaken in an authentic way. This authenticity is consistent with research concerning therapists' way of being as the foundation for effective clinical practice (Fife et al., 2014). The positive effects of TSD for clients included increased connection, comfort, trust and respect, and finding common ground. TSD also enabled clients to self-disclose more. All of these are outcomes found in the general TSD literature (Henretty & Levitt,

2010). However, these studies suggest that the cross-cultural context enhanced the importance of these uses and effects; building trust with therapists, for example, was especially crucial for EM groups who had experienced racism or discrimination.

Findings suggested that different EM groups may differentially value the use, and function of TSD. For Black-British, African-American and American-Indian clients, the most valuable function of TSD was its use in testing, and developing trust with their therapist (although feeling respected and equal in the relationship were also important). A common feature for these EM groups is that they have experienced oppression, and racism at the hands of White people (likely contributing to feelings of mistrust, and fear of discrimination). Despite these results, the evidence-base is not yet strong enough to firmly assert these findings regarding the differential value and perspective of TSD between EM groups.

A use of TSD more unique to cross-cultural therapy was to have conversations around race and cultural identities. Consistent with theory (Constantine & Kwong-Liem, 2003), TSD served a range of functions including validating clients' experiences of racism, therapists acknowledging their own shortcomings, or exploring cultural similarities and differences. These uses of TSD often had a positive impact: clients felt validated and believed by their therapist, or appreciated their honesty and commitment to an anti-racist stance. The importance of timing such a TSD may be crucial; if done before some form of therapeutic relationship is established, acknowledgement of one's own blind spots for example, could deter clients who are already predisposed to mistrust White therapists.

There were instances where therapists would deliberately choose not to use TSD with clients from different cultural backgrounds, as they were wary of potential being disrespectful of different cultural norms or values, or imposing their own values onto the client. Indeed, Lee (2014) indicated risks of TSD such as reinforcing a therapist-client hierarchical imbalance concerning cultural values, or, by recognising the cultural gulf between them, the client could feel distanced from the therapist.

Given the links between TSD and REC/cultural competence, situating this form of TSD within

the MCO framework (Owen et al., 2011, Owen, 2016) could be a means to mitigate some of these potential dangers. If therapists adopted a culturally humble approach with clients when using TSD, being consciously non-assuming, curious and respectful of clients' cultural identities, this could help to alleviate the potential pitfalls of imposing one's own cultural values or beliefs onto the client and the therapy work. If therapists viewed TSD within the dimension of cultural opportunities, they could listen for "cultural markers" whereby TSD may be indicated to be appropriate, creating opportunities with clients to assert an anti-racist stance for example, or to acknowledge their REC similarities and differences.

Findings from these studies indicated that therapists' level of comfort talking about REC issues influenced their ability to use TSD in this context. The more comfortable the therapist was, the more comfortable the client felt. This quite obviously links to the third dimension of the framework; cultural comfort. The more comfortable therapists become in initiating, attending, or responding to information regarding REC differences, the more able they will be to use TSD in an authentic and helpful way.

A limitation of the current evidence-base is that it mostly excludes people with "psychotic symptoms". This is unhelpful, given that a disproportionately large amount of people from EM groups receive a psychosis diagnosis (Gov.uk, 2021) and experiences of mistrust or paranoia may be even higher within this clinical population. Given the effectiveness of TSD in building trust, it may therefore be extremely useful. Rowan (2008) comments that TSD is "almost obligatory with patients…suffering from delusions or paranoid ideation…If a therapist does not disclose what he or she thinks, patients will…imagine, as the default option, that the therapist wants to trick them.".

One other limitation of this evidence-base is that most studies were conducted in North America. Whilst it should be acknowledged that the same issues regarding racism and oppression, and the need for therapist cultural competency, exist in the UK (Clegg et al., 2016), there could be issues with applicability of findings to UK healthcare systems.

Strengths and Limitations of this Review

The main strength of this review is that it is the first review to examine TSD specifically within the context of cross-cultural therapy relationships**.** A limitation of this review was that it focused on cross-cultural studies in which therapists were White, and clients were from EM groups. This neglects to attend to the experiences of using TSD for therapists from EM groups in cross-cultural therapy settings. Additionally, it should be recognised that this review in itself has a westernised/eurocentric perception of TSD. The principles and practices of TSD advocated within this review are governed by western psychology theory and therapy models (ideas which may greatly differ to those of other cultures).

Clinical Implications

This review's findings have many implications for clinical practice. Amongst them, the importance of using TSD in cross-cultural therapy contexts not superficially, but with authenticity and a lack of pretence, in order to build trust and connection; factors which may be especially important for clients from EM groups. TSD can also serve to illuminate common ground where appropriate, and validate clients' experiences of being a member of an EM group. Knox and Hill's practice guidelines should be followed, as these proved applicable to a cross-cultural context.

When using TSD to explore REC, there are strong links with improving therapists' cultural competency. Therapists could engage in further learning regarding the issues that affect clients from EM groups, such as racism within society (particularly its more subtle forms, such as micro-aggressions) in order to better understand clients' life experiences. Therapists should be comfortable and culturally humble, ensuring that their use of TSD empowers clients as opposed to imposing their own cultural beliefs or values. Supervision, or peer supervision groups may be a useful forum for therapists to increase awareness of their own cultural biases, to ensure they do not negatively influence the client's therapy process.

When looking for cultural markers, therapists should take the lead from the client, and be cognisant of clients' responses to the use of TSD, ideally having open conversations concerning its usefulness or relevance for the client, which can aid in deciding whether to use TSD (Constantine &

Kwong-Liem, 2003). It is important for therapists to remember that every client, and their relationship to their REC, is different, and to avoid making assumptions or generalisations. It should also be remembered that not all REC will be visible. For supervising therapists, being comfortable having conversations with supervisees about TSD around REC may be important; modelling or supporting therapists to use this with clients.

Research Recommendations

Future research could examine the effects of various types of TSD over multiple therapy sessions, to provide valuable information regarding the effectiveness of certain types of TSD at differing points in the therapeutic relationship, and the effectiveness of TSD on overall therapy outcomes (as opposed to an individual session outcome). Including behavioural or observational measures in addition to self-report measures would also provide a corroborative measure regarding how situational, client and therapist characteristics interact with TSD to affect clinical outcomes. Furthermore, future research could attempt to separate TSD from other potential mechanisms of change such as empathy, with carefully constructed experimental designs (e.g., involving therapy with and without TSD conditions).

Further research could address potential mediating factors on the effects of TSD, and examine more dyad-specific factors, such as the impact of intersectionality of other identities of client and therapist (e.g., gender, class, sexuality). Given the differential associations between cultural competence, cultural incompetence and therapeutic alliance found, researchers could measure for therapist cultural competence, and effects of cultural incompetence (such as racial microaggressions) on the effectiveness of TSD. Future research should also explore the experiences of using TSD for therapists from EM groups in cross-cultural therapy, as the few papers which examine this (Lijtmaer et al., 2013; Sady & Vaughn, 2005) indicate it could be an area of interest, particularly as the diversity of the psychological professions' workforce expands.

The evidence-base would benefit from focusing on TSD in cross-cultural therapy with clients experiencing psychosis, and with therapy involving interpreters. More research should also be co-produced by researchers, or clients, from EM groups. Finally, undertaking further research within the UK would enhance applicability of findings to therapy practice within the NHS, and the UK's health and social care system.

Conclusion

This review synthesised recent research to understand how TSD is used within cross-cultural therapy contexts, and its impact. Studies indicated many ways TSD is used in cross-cultural therapy contexts mirrored its use in more generalised therapy contexts; for example, to build trust and the therapeutic relationship, demonstrate common ground, or lessen the therapist-client hierarchy. Some of these effects were enhanced within a cross-cultural context, for instance building trust was especially important for clients from EM groups who felt mistrusting of services.

TSD was also used to invite conversations about REC; enabling therapists to validate clients' experiences of racism or assert their commitment to an anti-racist stance, acknowledging and discussing REC differences between therapists and clients, or improving understanding of clients' cultural identities. However, this was accompanied by risks. For instance, through TSD, therapists could inadvertently subjugate clients' cultural identities, and impose their own cultural values or beliefs onto the therapy work. Findings and clinical implications were considered in the context of the MCO framework for developing cultural competency to mitigate such risks. Many studies were limited by self-report methods, and future research should further explore mechanisms of change and client/therapist mediating factors.

References

Audet, C. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, *24*(2), 85–100. https://doi.org/10.1080/09515070.2011.589602

Audet, C. T., & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: A phenomenological study from the client perspective. *British Journal of Guidance & Counselling*, *38*(3), 327-342. https://doi.org/10.1080/03069885.2010.482450

Ballard, R. (2002) Race, Ethnicity and Culture. In M. Holburn (Ed), *New Directions in Sociology.* Causeway. https://doi.org/10.11588/xarep.00000283

Berg, J. H., & Wright-Buckley, C. (1988). Effects of racial similarity and interviewer intimacy in a peer counselling analogue. *Journal of Counseling Psychology*, *35*(4), 377. https://psycnet.apa.org/doi/10.1037/0022-0167.35.4.377

Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019) *Racial disparities in mental health: Literature and evidence review.* Race Equality Foundation. https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

Bitar, G., Kimball, T., Bermúdez, J., & Drew, C. (2014). Therapist self-disclosure and culturally competent care with Mexican–American court mandated clients: A phenomenological study. *Contemporary Family Therapy, 36*(3), 417-425. http://dx.doi.org/10.1007/s10591-014-9308-4

Bridges, N. A. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy: Theory, Research, Practice, Training, 38*(1), 21–30. https://psycnet.apa.org/doi/10.1037/0033-3204.38.1.21

Burkard, A. W., Knox, S., Groen, M., Perez, M., & Hess, S. A. (2006). European American therapist self-disclosure in cross-cultural counseling. *Journal of Counseling Psychology, 53*(1), 15-25. https://10.1037/0022-0167.53.1.15

Cashwell, C. S., Shcherbakova, J., & Cashwell, T. H. (2003). Effect of client and counselor Ethnicity on Preference for counselor disclosure. *Journal of Counseling & Development*, *81*(2), 196-201. https://psycnet.apa.org/doi/10.1002/j.1556-6678.2003.tb00242.x

Centre for Social Justice. (2020) Facing The Facts: Ethnicity and Disadvantage In Britain. Disparities in education, work, and family. https://www.centreforsocialjustice.org.uk/wp-content/uploads/2020/11/CSJJ8513-Ethnicity-Poverty-Report-FINAL.pdf

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work. *Journal of Counseling Psychology, 56*(4), 521-536. https://psycnet.apa.org/doi/10.1037/a0016905

Chang, D. F., & Yoon, P. (2011). Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships. *Psychotherapy Research*, *21*(5), 567-582. https://doi.org/10.1080/10503307.2011.592549

Cherbosque, J. (1987). Differential effects of counselor self-disclosure statements on perception of the counselor and willingness to disclose: A cross-cultural study. *Psychotherapy: Theory, Research, Practice, Training, 24*(3), 434–437. https://doi.org/10.1037/h0085736

Clegg, S., Heywood-Everett, S. & Siddiqi, N. Siddiqi. (2016). A review of cultural competence training in UK mental health settings. *British Journal of Mental Health Nursing 5*(4). 176–183. https://doi.org/10.12968/bjmh.2016.5.4.176

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counselor relationships. *Journal of Counseling Psychology*, *54*(1), 1. https://doi.org/10.1037/0022-0167.54.1.1

Constantine, M., & Kwong-Liem, K.K. (2003). Cross-cultural considerations of therapist self-disclosure. *Journal of Clinical Psychology, 59(5)*, 581-588. https://doi.org/10.1002/jclp.10160

Davis, D. E., DeBlaere, C., Owen, J., Hook, J. N., Rivera, D. P., Choe, E., Van Tongeren, D. R., Worthington, E. L., Jr., & Placeres, V. (2018). The multicultural orientation framework: A narrative review. *Psychotherapy, 55*(1), 89–100. https://doi.org/10.1037/pst0000160

Dixon, L., Adler, D., Braun, D., Dulit, R., Goldman, B., Siris, S., Sonis, W., Bank, P., Hermann, R., Fornari, V., & Grant, J. (2001). Reexamination of Therapist Self-Disclosure. *Psychiatric Services, 52*(11), 1489-1493. https://doi.org/10.1176/appi.ps.52.11.1489

Elias, A. & Paradies, Y. (2021) The Costs of Institutional Racism and its Ethical Implications for Healthcare. *Bioethical Inquiry 18*, 45–58. https://doi.org/10.1007/s11673-020-10073-0

Elliot, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, *48*(1), 43. https://psycnet.apa.org/doi/10.1037/a0022187

Fife, S. T., Whiting, J. B., Bradford, K., & Davis, S. (2014). The therapeutic pyramid: A common factors synthesis of techniques, alliance, and way of being. *Journal of Marital and Family Therapy*, *40*(1), 20-33. https://doi.org/10.1111/jmft.12041

Freud, S. (1912/1958). *Recommendations to physicians practicing psycho-analysis. Standard edition of the complete psychological works of Sigmund Freud. Vol XII*. Hogarth Press.

Geller, J. D., & Farber, B. A. (1997). *Why therapists do and don't disclose*. [Paper presentation]. American Psychological Association, Chicago, IL, United States.

Gibson, M. F. (2012). Opening-up: Therapist's self-disclosure in theory, research, and practice. *Clinical Social Work Journal*, *40*(3), 287–296. https://doi :10.1007/s10615-012-0391-4

Gov.uk, (2019) *Writing about ethnicity*. Gov.uk. https://www.ethnicity-facts figures.service.gov.uk/style-guide/writing-about-ethnicity

Hanly, C. (1998). Reflections on the analyst's self-disclosure. *Psychoanalytic Inquiry, 18(4),* 550 –565. https://doi:10.1080/07351699809534211

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A Lab Test and Algorithms for Identifying Clients at Risk for Treatment Failure. *Journal of Clinical Psychology, 61(2),* 155-163. https://psycnet.apa.org/doi/10.1002/jclp.20108

Helms, J.E., & Cook, D.A. (1999). *Using race and culture in counselling and psychotherapy: Theory and process.* Allyn & Bacon.

Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review, 30*(1), 63-77. https://10.1016/j.cpr.2009.09.004

Hill, C.E., & Knox, S. (2002). Self-disclosure. In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp.255–265). Oxford University Press.

Hill, C. E., Mahalik, J. R., & Thompson, B. J. (1989). Therapist self-disclosure. *Psychotherapy: Theory, Research, Practice, Training, 26*(3), 290–295. https://doi.org/10.1037/h0085438

Hill, C.E. & O'Brien, K. M. (1999). *Helping Skills: Facilitating exploration, insight & action*. American Psychological Association.

Hill, C. E., Thompson, B. J., Cogar, M. C., & Denman, D. W. (1993). Beneath the surface of long-term therapy: Therapist and client report of their own and each other's covert processes. *Journal of Counseling Psychology*, *40*(3), 278-287. https://psycnet.apa.org/doi/10.1037/0022-0167.40.3.278

Hong, Q.N., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M.C., & Vedel, I. (2018). *Mixed*

Methods Appraisal Tool (MMAT). http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

Jackson, J. M. (1990). The role of implicit communication in therapist self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 93–102). Plenum Press https://psycnet.apa.org/doi/10.1007/978-1-4899-3582-3_7

Jourard, S. M. (1971). *The transparent self.* Van Nostrand Reinhold.

Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: an overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology*, *11*(2), 113-129. https://doi.org/10.1037/1099-9809.11.2.113

Kim, B. S. K., Hill, C. E., Gelso, C. J., Goates, M. K., Asay, P. A., & Harbin, J. M. (2003). Counselor self-disclosure, East Asian American client adherence to Asian cultural values, and counselling process. *Journal of Counseling Psychology, 50*(3), 324-332. https://10.1037/0022-0167.50.3.324

King, J., Reynolds, K., Goodbody, L. and Chahal, K. 2013. Widening access to clinical psychology: regional and local initiatives. *Clinical Psychology Forum*, 244. https://repository.canterbury.ac.uk/item/86x0w/widening-access-to-clinical-psychology-regional-and-local-initiatives

Kivlighan III, D. M., Jung, A. K., Berkowitz, A. B., Hammer, J. H., & Collins, N. M. (2019). 'To show or No-show'? Therapist Racial-ethnic Disparities in Clients' Nonattendance in Therapy. *Journal of College Student Psychotherapy*, *33*(1), 1-13. https://doi.org/10.1080/87568225.2018.1424597

Knox, S., & Hill, C. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology, 59*(5), 529–539. https://doi.org/10.1002/jclp.10157

Lee, E. (2014). A therapist's self-disclosure and its impact on the therapy process in cross-cultural encounters: Disclosure of personal self, professional self, and/or cultural self? *Families in Society, 95*(1), 15-23. https://10.1606/1044-3894.2014.95.3

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage publications.

Lijtmaer, R., Moodley, R., & Sunderani S. (2013). The Therapist's Self Disclosure in Cross-Cultural Treatment. *International Journal of Psychological and Behavioral Sciences, 7*(3), 789-793. https://doi.org/10.5281/zenodo.1082507

Mahalik, J. R., Van Ormer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 189–201). American Psychological Association. https://doi.org/10.1037/10343-009

Maramba, G.G., & Nagayama Hall, G.C. (2002). Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural Diversity and Ethnic Minority Psychology,8*(3), 290–297. https://psycnet.apa.org/doi/10.1037/1099-9809.8.3.290

Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy, 43*(1), 85-98. https://doi.org/10.1037/0033-3204.43.1.85

Memon, A., Taylor, K., Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016) Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ Open, 1-9.* http://dx.doi.org/10.1136/bmjopen-2016-012337

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PloS Med 6(*6): e1000097. https://doi.org /10.1371/journal.pmed1000097

Moller, N. P., Ryan, G., Rollings, J., & Barkham, M. (2019). The 2018 UK NHS Digital annual report on the Improving Access to Psychological Therapies programme: a brief commentary. *BMC psychiatry*, *19*(1), 252. https://doi.org/10.1186/s12888-019-2235-z

NHS, The Information Centre for Health & Social Care. (2013). *NHS Workforce: Summary of staff in the NHS: Results from September 2012 Census*. https://files.digital.nhs.uk/publicationimport/pub10xxx/pub10392/nhs-staf-2002-2012-over-rep.pdf

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (pp. 113–141). American Psychological Association.

Office for National Statistics (2017). *Research report on population estimates by characteristics.* https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/methodologies/researchreportonpopulationestimatesbycharacteristics#data-sources

Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50(4),* 496 –502. https://psycnet.apa.org/doi/10.1037/a0034617

Owen, J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research*, *27*(1), 102-111. https://doi.org/10.1080/10503307.2015.1078517

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice*, *47*(1), 30 -37

https://psycnet.apa.org/doi/10.1037/pro0000046

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy*, *48*(3), 274-282. https://psycnet.apa.org/doi/10.1037/a0022065

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology.* Taylor & Frances/Routledge.

Phiri, P., Rathod, S., Gobbi, M., Carr, H., & Kingdon, D. (2019). Culture and therapist self-disclosure. *The Cognitive Behaviour Therapist, 12*, 1-20. https:// doi:10.1017/S1754470X19000102

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry, 4*, 65-79. https://doi.org/10.2217/NPY.13.89

Roberts, J. (2005). Transparency and self-disclosure in family therapy: dangers and possibilities. *Family process*, *44*(1), 45-63. https://doi.org/10.1111/j.1545-5300.2005.00041.x

Robinson, M., Keating, F., & Robertson, S. (2011). Ethnicity, gender and mental health. *Diversity in Health & Care*, *8*(2). 81-92. http://diversityhealthcare.imedpub.com/ethnicity-gender-and-mental-health.pdf

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95–103. https://doi: 10.1037/h0045357

Rowan, J. (2008). A triumph for the humanistic approach. [Review of the book *Psychotherapy of Personality Disorders: States of Mind and Interpersonal Cycles* by G. Dimaggio, A. Semerari, A. Carcione, G. Nicolò, & M. Procacci]. amazon.co.uk,

https://www.amazon.co.uk/Psychotherapy-Personality-Disorders-Metacognition-Interpersonal/dp/0415412706

Sady, S., & Vaughn, K. (2005). *The Latino therapist's use of self-disclosure in sessions as a tool to ımprove the therapeutic relationship* [Ph. D. Thesis, Alliant International University]. California School of Professional Psychology.

Shin, S. M., Chow, C., Camacho-Gonsalves, T., Levy, R. J., Allen, I. E., & Leff, H. S. (2005). A Meta-Analytic Review of Racial-Ethnic Matching for African American and Caucasian American Clients and Clinicians. *Journal of Counseling Psychology*, *52*(1), 45-56. https://psycnet.apa.org/doi/10.1037/0022-0167.52.1.45

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice (4th ed.)*. Wiley

Sunderani, S., & Moodley, R. (2020). Therapists' perceptions of their use of self-disclosure (and nondisclosure) during cross-cultural exchanges. *British Journal of Guidance & Counselling, 48*(6), 741-756. https://10.1080/03069885.2020.1754333

Terrell, F., & Terrell, S. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among Black clients. *Journal of Counseling Psychology, 31*(3), 371–375. https://doi.org/10.1037/0022-0167.31.3.371

Thompson, C. E., & Jenal, S. T. (1994). Interracial and intraracial quasi-counseling interactions when counsellors avoid discussing race. *Journal of Counseling Psychology, 41*(4), 484-491. https://10.1037/0022-0167.41.4.484

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counsellor race, and black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology, 41*(2), 155-161. https://10.1037/0022-0167.41.2.155

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social work*, *11*(1), 80-96. https://doi.org/10.1177%2F1473325010368316

Twohey, D. & Lokken, J.M, (2004). American Indian perspectives of Euro-American counseling behavior. *Journal of Multicultural Counseling and Development, 32*, 320-331. https://link.gale.com/apps/doc/A127796993/HRCA?u=anon~812a4fec&sid=googleScholar&xid=6a1da07e

Valente S. M. (2017). Managing Professional and Nurse-Patient Relationship Boundaries in Mental Health. *Journal of psychosocial nursing and mental health services*, *55*(1), 45–51. https://doi.org/10.3928/02793695-20170119-09

Wetzel, C. G., & Wright-Buckley, C. (1988). Reciprocity of self-disclosure: Breakdowns of trust in cross-racial dyads. *Basic and Applied Social Psychology*, *9*(4), 277-288. https://doi.org/10.1207/s15324834basp0904_3

White, M. (2007). *Maps of narrative practice.* W W Norton & Co.

York, K. (2020) BAME representation and psychology. *The Psychologist, 33 (*4). https://thepsychologist.bps.org.uk/volume-33/january-2020/bame-representation-and-psychology

Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration*, *23*(1), 59-74. https://psycnet.apa.org/doi/10.1037/a0031783

Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations*. American Psychological Association. https://psycnet.apa.org/doi/10.1037/11563-

Section B: Empirical paper

"It's a Dent, Not a Break":

An exploration of how Case Managers Understand and Navigate Boundaries in Early Intervention in Psychosis Services

Overall Word Count: 8,000

July 2021

Abstract

Early Intervention in Psychosis Services (EIPS) is a unique service model for people said to be experiencing a first episode of psychosis. They are intensive, case-management services which adopt an assertive outreach approach, employing flexible boundaries to meet clients in the community and support them towards recovery and holistic goals. Current boundary theory is therefore not easily applied to this clinical context. This study aimed to explore how case-managers in EIPS develop their understanding and practice around navigating boundaries. Participants were 13 EIPS case-managers. Semi-structured interviews with participants were analysed using grounded theory.

A concentric model emerged, defining different layers of influence impacting case-managers' navigation of boundaries. This included higher governing levels (e.g., professional codes of conduct), factors and challenges specific to EIPS culture, and individual decision-making processes. The model also depicted how case-managers navigated boundaries with clients over time. A flexible, case-by-case approach was adopted in response to challenges. This model adds to current boundary theory outside of therapy contexts, and findings suggest clinical implications for how case-managers can jointly construct appropriate boundaries with clients, and discuss dilemmas using the team resource. This model can be used as a tool in clinical practice to guide clinicians' thinking and reflection around boundaries within EIPS.

Keywords: boundaries, professional boundaries, boundary management, early intervention in psychosis, case-managers, assertive engagement, assertive outreach

Introduction

The Concept of Boundaries in Clinical Practice

Boundaries in clinical practice have been defined as 'the edge of appropriate professional behaviour' (Aravind et al., 2012). Boundaries establish clear roles for clinicians and service-users, and define the therapeutic territory. However, boundaries may be crisp, flexible, or fuzzy, depending on the role in question and other relevant factors (such as the service or therapy model, cultural or social factors, individual client characteristics or clinical context) (Aravind et al., 2012; Gutheil & Gabbard, 1993). Gutheil and Gabbard (1993) suggest well-constructed, "safe" boundaries facilitate a secure, therapeutic space which enables client recovery. They theorise that providing predictable and containing external boundaries (such as meeting at the same time, in the same room each week), enables psychological boundaries to be crossed through a variety of psychotherapy mechanisms (e.g., empathy, projection, transference). In contrast, "unsafe boundaries" can involve boundary violations, which can arise from either client or clinician, but constitute exploitation of the client, potentially causing harm to both parties. For example, a clinician and a client beginning a romantic relationship would be considered a boundary violation, and reflect a breach of trust in the relationship on the part of the clinician (Simon, 1992; Williams & Swartz, 1998). Considering boundaries is important, given that it constitutes a component of the therapeutic relationship, which in itself is a key mechanism of change, and one of the most important factors affecting clinical outcomes (Norcross, 2010).

Gutheil and Gabbard (1998) define a distinction between boundary violations, and boundary crossings. Whilst boundary violations are potentially harmful to either party and the therapeutic relationship, a boundary crossing refers to a deviation from standard practice that is "harmless, non-exploitative, and possibly supportive of the therapy itself". A boundary crossing can have productive therapeutic aims. For example, a client reaches out to their therapist for a hug following a significant bereavement. The therapist accepts the hug, with the aims of responding in a human way, and avoiding their client feeling rejected (Gutheil & Gabbard, 1998). However, such differentiations are

not always clear cut, and should take into account situation and client-specific factors, including the clinical context and rationale, and, the possible benefits versus harms to the client (Pope & Keith-Spiegel, 2008). Another example of a boundary crossing could be clinician self-disclosure (SD). In response to a client expressing a difficult experience, a therapist may wish to convey they have shared similar difficulties, providing some personal information pertaining to this. This could have therapeutic mechanisms of normalising universal experiences, demonstrating empathy or building trust, thus strengthening the therapeutic alliance (Henretty & Levitt, 2010). However, the same boundary crossing in the context of a client who has experienced traumatic boundary violations in their past, and who may be more sensitive to subsequent boundary breeches (or experiences that feel similar), could experience this as harmful, and a violation of their boundaries (Pope & Keith-Spiegel, 2008). The task of navigating boundaries therefore seems to be somewhat subjective, relying on job role, training, clinical judgement, and experience.

Clinical Boundaries Outside of a Therapy Context

Most of the research around boundaries has occurred within the psychological professions, with a consensus amongst therapy disciplines being that how boundaries are approached and managed within therapy has an impact upon the therapeutic relationship (Smith & Fitzpatrick, 1995). However, key differences in mental healthcare in the community within and outside of the psychotherapy context have been noted, which impact upon boundaries. Obvious distinctions include the nature and level of contact and intervention, which is different for mental health practitioners who, for example, when case-managing, will see and talk to clients as and when is needed, in comparison to therapists, who tend to see clients for discrete, pre-determined time frames (such as one hour weekly) (Priebe & McCabe, 2006; Williams & Swartz, 1998). This indicates that a different frame, or practice around boundaries may be required in comparison to the traditional therapy context.

Boundaries With People Experiencing Psychosis and the EIPS Model

People reportedly experiencing a First Episode of Psychosis (FEP) often experience a sense of loss in many domains, including social isolation/exclusion, a loss of confidence, sense of identity and, for some, connection with reality (Killaspy et al., 2014; Tindall et al., 2018). As a result, service-users often have high levels of mistrust, fear, confusion, and distress, and are often reluctant to engage with services (Doyle et al., 2014; Tindall et al., 2018). Given the established strong relationship between childhood adversity and psychosis, and the socially based causes of psychosis (Read et al., 2014), it can be argued that people said to be experiencing a FEP require trauma-informed care in their interactions with clinicians and services, in which their social isolation and disconnection is not reinforced. A critical review on therapeutic relationships between clients experiencing psychosis and mental health clinicians cited the lack of clarity in the theoretical and research literature regarding navigating boundaries with clients with psychosis in community case-management settings (Farrelly & Lester, 2014). The clinical utility and feasibility of maintaining traditional professional boundaries is questioned, arguing that such boundaries (intended for therapeutic benefit) may indeed reinforce the disconnection and social isolation of people with psychosis (Farrelly & Lester, 2014). Alternatively, an entire lack of boundaries may be emotionally taxing on the clinician, or endanger the well-being of either party (Farrelly & Lester, 2014).

Within Early Intervention in Psychosis Services (EIPS), an “assertive outreach” (or “assertive engagement”), intensive case-management model is usually adopted (Anderson et al., 2010), and is endorsed by the Early Intervention in Psychosis Network (EIPN); a national quality improvement and accreditation network for EIPS in the UK. Assertive engagement refers to a style of working whereby clients are not discharged quickly if they disengage, and case-managers adopt a flexible and persistent approach to working with clients and families, with a focus on building rapport at the client’s own pace, and establishing a relationship over time (EIPN, 2018). EIPS are deliberately intensive but time limited services (with input ranging from 2-5 years (EIPN, 2018) with a multidisciplinary approach (MDT) for people experiencing a FEP, offering holistic support across a range of domains (including social, education/occupation, family intervention, individual therapy),

with broad goals of achieving “psychotic symptom” remission, relapse prevention and social recovery (Birchwood et al., 2014).

The case-manager (CM) role is particularly important within EIPS, with Wong et al. (2019) describing case-management as the “linchpin” of EIPS, supporting clients across these domains. This is due to the small caseloads and high levels of contact which allow for meaningful relationship building, close support, and continuity of care (alongside the more generalised duties of a CM). There is a culture of “standing alongside” clients, flattening the traditional patient-clinician hierarchy, and for CMs to position themselves as a supporter, aiding the client to achieve their goals (EIPN, 2018). The term CM is used within the literature, and so will be used in this research, however, is interchangeable with the terms “Care Co-ordinator” or “Lead Practitioner” which tend to be used more within services.

Although clients are individually case-managed, treatment is delivered by a MDT, and emphasis is placed on clinicians’ interpersonal skills in relation to working with young people especially, providing needs-based treatment in youth friendly ways (McGorry et al., 1996), due to the predominantly younger client group who experience FEP (Kirkbride et al., 2006).

In contrast to many mental health service models, EIPS promotes flexibility with regards to boundaries with clients. CMs will often meet with clients outside of the traditional clinic room setting, such as in clients’ homes, cafés, gyms, or public settings, or will support clients not only emotionally but also practically (e.g., taking a client to a food bank in their own car). These boundaries are flexed to encourage engagement and build relationships, or in relation to other client goals such as increasing confidence, social interaction or independence in the community (Farrelly & Lester, 2014). CMs also typically use more flexible communication methods than many services, such as texting or emailing with clients (from work phones or emails), to enhance accessibility.

This way of working, inevitably, can push the “traditional” clinical boundaries, and render personal/professional boundaries particularly porous for CMs. For example, there can be more clinician self-disclosure, and dilemmas navigating the role of “supporter” versus “friend”, than tends

to occur within a traditional therapy context, or other common settings to which boundary theory has been applied (such as forensic settings or “Personality disorder” services). Hinshelwood (1999) theorised it is important to establish strong and consistent boundaries with clients who attract a diagnosis of “personality disorder”, in order to provide safety and containment, and to model healthy relationships and boundaries. This avoids clients repeating problematic historical interpersonal patterns with clinicians, resulting in both clinician and client feeling violated. The flexible and porous nature of boundaries within EIPS is therefore something which these psychological models of therapeutic relationships and boundaries do not adequately address (Farrelly & Lester, 2014).

Relationship Between Engagement and Boundaries

Whilst the benefits of EIPS for FEP compared with routine care have been widely published (Garety et al., 2006; Harvey et al., 2007), recent research indicates that client engagement is still a significant challenge for EIPS, with disengagement rates ranging from 20.5-40% across studies (Doyle et al., 2014). The Early Youth Engagement (EYE) Project examined facilitators and barriers to engagement within EIPS. They found that barriers to engagement included “notable staff stress”, and facilitators included “being able to contact staff at any time” and “informal sessions” (Greenwood et al., 2013). A similar study found “case-manager-client relationship” to be the key facilitator of engagement, an element of which was having a “relaxed attitude” (Tindall et al., 2018). Such factors may be particularly important given the younger client group accessing EIPS, who may prefer a more informal style of interaction (Tindall et al., 2018).

These factors seemingly relate to how CMs navigate boundaries with clients in EIPS. The evidence-base, and lack of applicable theory (Farrelly & Lester, 2014) suggests more thinking around how boundaries are navigated by CMs with people said to be experiencing FEP is needed.

Rationale for this Research

Considering the clinical issues unique to people with FEP, and the apparent relationship between effectively navigating boundaries and engagement; these are dilemmas which need to be explored in greater detail. This will allow for better understanding, and the development of a theory which CMs in EIPS can draw on when navigating boundaries with clients.

Research Aims

This study aimed to develop a grounded theory (GT) to explore how CMs in EIPS developed their understanding and practice around navigating boundaries, given the inherent challenges with this clinical population and service model. Specifically, this study aimed to answer the following questions:

1. How did CMs in EIPS navigate boundaries with clients in their clinical practice? What informed their decision- making?
2. What were the benefits and challenges around boundaries that CMs in EIPS experienced?
3. How did they overcome these challenges?

Method

Design

A qualitative, GT methodology was used (Glaser & Strauss, 1967), which allows for an in-depth understanding of an under-researched area, and the generation of theory which is grounded in participants' experiences in everyday clinical practice (Elliot & Lazenbatt, 2005). The research was approached from a constructivist epistemological perspective. This stance recognises that humans participate in constructing "knowledge", through influences such as language, social discourses, and power (Clarke, 2005). It therefore acknowledges the researcher's role in the analysis. The researcher and participant are co-constructing knowledge, or understanding, through the inquiry process (Corbin, 2009). The researcher therefore collects and analyses the data whilst being cognisant of their own experiences, assumptions, and biases they may bring (Charmaz, 2014). GT was undertaken following Charmaz's methodology (Charmaz, 2014), which fits with this epistemology.

Ethical Considerations

This study received ethical approval from Canterbury Christchurch University ethics panel (appendix 3) and NHS Health Research Authority approval (appendix 4).

Participants were advised in the Information sheet that data would be anonymised and handled confidentially. They could withdraw consent to be contacted about the study at any time. Data and related information (e.g., research diary) were stored securely on an encrypted and password-protected memory stick (a "safestick") for transcription/analysis, and the original interview recording destroyed. Participants were assigned a number which was used to label their interview recording, transcript, and corresponding notes, to maintain anonymity. A log of each participant's assigned number was kept in a separate password-protected folder on the safestick. Only the researcher and their academic supervisor had access to personal data.

Participants were made aware of the nature of the research questions before consenting, and were advised they were not obliged to answer any questions they did not feel comfortable answering. If any participants felt distressed by the interview, the researcher was available to spend time debriefing with the participant directly afterwards, and they would also have been encouraged to speak to their manager at the earliest opportunity. However, this circumstance did not arise. Participants were made aware in the information sheet, consent form and verbally about the researcher's duty to break confidentiality if a previously unreported serious boundary violation was reported by a participant, or there were serious safeguarding concerns. This did not occur, although if it had, concerns would have been raised in line with the recruiting trust's organisational policies.

Participants

Participants were 13 CMs who met the inclusion criteria (see table 7), recruited from four EIPS from a trust in the south-east of England, which comprised of both urban and rural areas.

Table 7

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Participants must be a qualified Healthcare Professional, working as a CM (Lead Practitioner) in EIPS • Participants must have been working in any EIPS for at least 4 months*	• CM's who have worked in any EIPS for *less than* 4 months

**An exclusion criterion for CMs who had worked in an EIPS for less than four months was devised, due to the unique model and assertive outreach approach used in EIPS, which, for those not familiar, could take time to learn and adjust to.*

Participants comprised a range of ages (*M*= 39 years), clinical experience and professions, although most were mental health nurses. On average, participants had been qualified 10.8 years, and had worked in EIPS for 3.8 years. Most participants were White-British, although during theoretical sampling attempts were made to recruit participants of different ethnicities, as earlier data suggested this could impact on navigating boundaries (see appendix 5). Table 8 outlines the demographic characteristics of each participant.

Table 8

Demographic characteristics of participants

Participant	Age	Gender	Ethnicity	Profession	Years in EIPS	Years Qualified	Previous clinical experience
1	37	Male	White-British	MHN	4-6	4-6	Homeless, forensic services
2	32	Female	White-British	MHN	1-3	1-3	Inpatient CAMHS, children services
3	36	Female	White-British	OT	1-3	1-3	Hospital/community physical health
4	49	Male	White-British	MHN	10-15	16-20	Substance misuse services, CMHT
5	32	Female	White-British	SW	4-6	4-6	Children services, CMHT
6	26	Female	White-British /French	MHN	1-3	1-3	Inpatient CAMHS
7	34	Male	White-British	MHN	1-3	1-3	Inpatient – women's "PD" Services
8	42	Female	White-British	MHN	1-3	10-15	Inpatient, female acute, dementia unit
9	27	Female	White-British	MHN	1-3	1-3	LD services
10	43	Female	Black Caribbean /White British	MHN	1-3	10-15	CMHT, 3rd sector organisations
11	44	Male	White-British/Irish	OT	4-6	16-20	3rd sector, physical health, social services
12	56	Female	White-British	MHN	4-6	>25	Forensic services
13	53	Male	White-British	MHN	1-3	>25	Inpatient, crisis team, CMHT

Key: *MHN = Mental Health Nurse, OT =Occupational Therapist, SW = Social Worker, CAMHS = Children and Adolescent Mental Health Services, CMHT = Community Mental Health Team, PD = Personality Disorder, LD = Learning Disability. Regarding Years in EIPS and Years Qualified, a range is given to help protect participant anonymity.*

Data Collection

A document providing an overview of the study and participant requirements (appendix 6) was emailed to the team leaders of chosen EIPS in the recruiting NHS trust. The researcher subsequently liaised with team leaders to arrange a date to visit teams to inform them about the study. A participant information sheet (appendix 7) was emailed to team leaders prior to the researcher's visit, for them to forward on to CMs within their team. The researcher attended a team meeting for each team virtually to discuss the study (due to COVID-19 restrictions), and collected NHS email addresses of eligible participants who registered their interest. The researcher then emailed interested participants, providing the information sheet again, and the opportunity to discuss any questions or concerns. Interview times were arranged with those participants who agreed to take part. Before the interview, participants were asked to read and sign a consent form (appendix 8), and were encouraged to ask any clarifying questions or concerns before consenting. Participants were asked to provide relevant demographic information (appendix 9) if they felt comfortable to share this.

Due to the difficulties in recruiting participants within busy NHS services, opportunity sampling was initially used. However, within GT, data collection and analysis are undertaken concurrently, using theoretical sampling (Glaser & Strauss, 1967). Based on data from initial interviews, theoretical sampling guided subsequent data collection as much as possible. This meant that decisions about what data to collect next (and from whom) were made based on the ideas emerging from the concurrent analysis, for example recruiting more men, or participants who had been qualified longer. See appendix 5 for examples of this within the researcher's reflective research diary.

Semi-structured interviews were conducted via videoconferencing due to COVID-19 restrictions, and recorded using a Dictaphone. The interview schedule (appendix 10) was developed following consultation with Salomons Advisory Group of Experts, and the researcher's academic supervisor. Questions were open and non-leading, allowing participants to respond freely and with

depth. However, prompts were available to support questions and aid conversation where needed. In-keeping with semi-structured interviews, questions and conversation often deviated from the interview schedule where this was relevant to the research questions, and in line with GT, the interview schedule was adapted over time based on theoretical sampling, and the perceived gaps in the data (Glaser,1978). Interviews lasted between 45-82 minutes.

Interviews were transferred to the safestick and transcribed/analysed by the researcher. Recruitment ended once "theoretical sufficiency" (Dey, 1999) was reached, meaning a depth of understanding from the data sufficient for categories, and relationships between categories to be well-developed, enabling generation of a theory.

Data Analysis

Interviews were analysed using open, selective, and theoretical coding (Charmaz, 2014; Urqhart, 2012). Table 9 outlines the coding process, informed by Charmaz's methodology. Examples of Open Coding are in a transcript extract in appendix 11. Examples of selective and theoretical coding, memos, integrative maps and the formation of the theory are in appendices 12-15.

Table 9

Stages of coding in data analysis

Coding stage	Description
1. Open coding	Transcripts were coded line-by-line, and assigned descriptive or analytic labels which captured descriptions of feelings, actions or explanations of what is happening in that section of text. Where possible, codes were gerunds (action words) or meanings, which provided easier access to the underlying processes occurring around navigating boundaries. These could be implicit, or tacit assumptions. See appendix 11 for an extract of open coding.

2.	Selective (or focused) coding	Codes from each transcript were grouped together into tentative categories related to the research questions. These were developed through a constant comparison process between newly emerging and previously categorised data, so that re-groupings or category amendments could occur. See appendix 12 for a table from this stage of the coding process.
3.	Theoretical coding	Categories were compared to see how they related to one another, and integrated into a theory outlining connections between the categories/subcategories. This process was aided through selective coding categories and memos (see appendices 12 and 13) which documented ideas about possible relationships between categories or subcategories (Glaser, 1978). These relationships were consolidated by returning to the evidence in the data (the transcripts). Integrative maps (Strauss, 1987) were used to visually map how categories related to one another (an example is in appendix 14). Through the constant comparison between memos, categories and transcripts, a theory regarding the navigation of boundaries within EIPS was generated and regenerated directly from the data.

Finalising the Theory

Towards the end of the theoretical coding stage, through constant comparison between memos, categories and transcripts, and using integrative maps (Strauss, 1987) (appendix 14) a theory was generated and regenerated directly from the data until the model described in the results section was finalised. The formation of the theory and various stages involved in refining the model are seen in appendix 15.

Quality Assurance

The CASP qualitative research checklist was used to plan for quality assurance, alongside Elliot et al., (1999)'s guidelines for quality GT research. Following this, the quality of the research was ensured through several processes (Yardley, 2000).

To ensure researcher reflexivity, prior to data collection the researcher engaged in a bracketing interview with a peer, to illuminate the preconceptions and biases they held around navigating boundaries. A resulting researcher positioning statement can be found in appendix 16. The researcher also kept a reflective research diary throughout the research, enabling them to remain alert to their own biases, and responses to interviews, and to "bracket" these off from the interview process and resulting data as much as possible (Berger, 2015). Several sections of transcripts were co-coded by the researcher's academic supervisor, which aided in drawing attention to potential bias or differences in interpretation. Emerging and reorganisation of categories was discussed with the supervisor throughout data analysis. Additionally, transparency throughout analysis and theory development was ensured through the following processes:

- Use of memos (appendix 13)
- extracting relevant quotes to support emerging or reorganised categories across transcripts
- Integrative map (appendix 14)

The original model (appendix 17) was shared with a subset of participants for respondent validation (Lincoln & Guba, 1985). Their feedback was considered, and adaptations made to create the finalised model presented in the results. See appendix 18 for sections of transcripts from the respondent validation interviews.

Results

Model Overview

This study aimed to develop a theory to understand how CMs navigate boundaries with clients within EIPS, grounded in the day-to-day clinical practice of CMs. Data analysis resulted in a

concentric circular model, which depicts four different layers of influence which impacted CMs' navigation of boundaries with clients, with each layer representing a category:

- Professional bodies/organisation policy
- EIPS culture
- Team processes
- Individual decision-making processes

Within each layer are subcategories relevant to the navigation of boundaries in that layer, such as "sharing decision-making" within the team processes layer. The subcategories within the individual decision-making processes layer, whilst important to CMs' navigation of boundaries, were arguably more generalisable clinical skills being applied within an EIPS context. They are therefore presented briefly, with further information in appendix 23. Additionally, some processes took place across layers. Examples include the "Learning and Calibrating cycle", a process of learning for individuals not only from their own clinical experiences, but also from colleagues and the EIPS culture. As this cycle depicts fairly universal learning processes (situated within the EIPS context), details of this cycle can be found in appendix 19.

The model conveys that navigating boundaries in this context is a dynamic interaction; there are links between the layers of influence, and many of the subcategories are closely connected. Earlier versions of the model involved many arrows conveying these relationships, however this made the model too busy and confusing, thus the reader should bear in mind when studying the model that layers and subcategories are closely linked. The challenges participants faced around boundaries have been interwoven throughout the subcategories, where these were most pertinent.

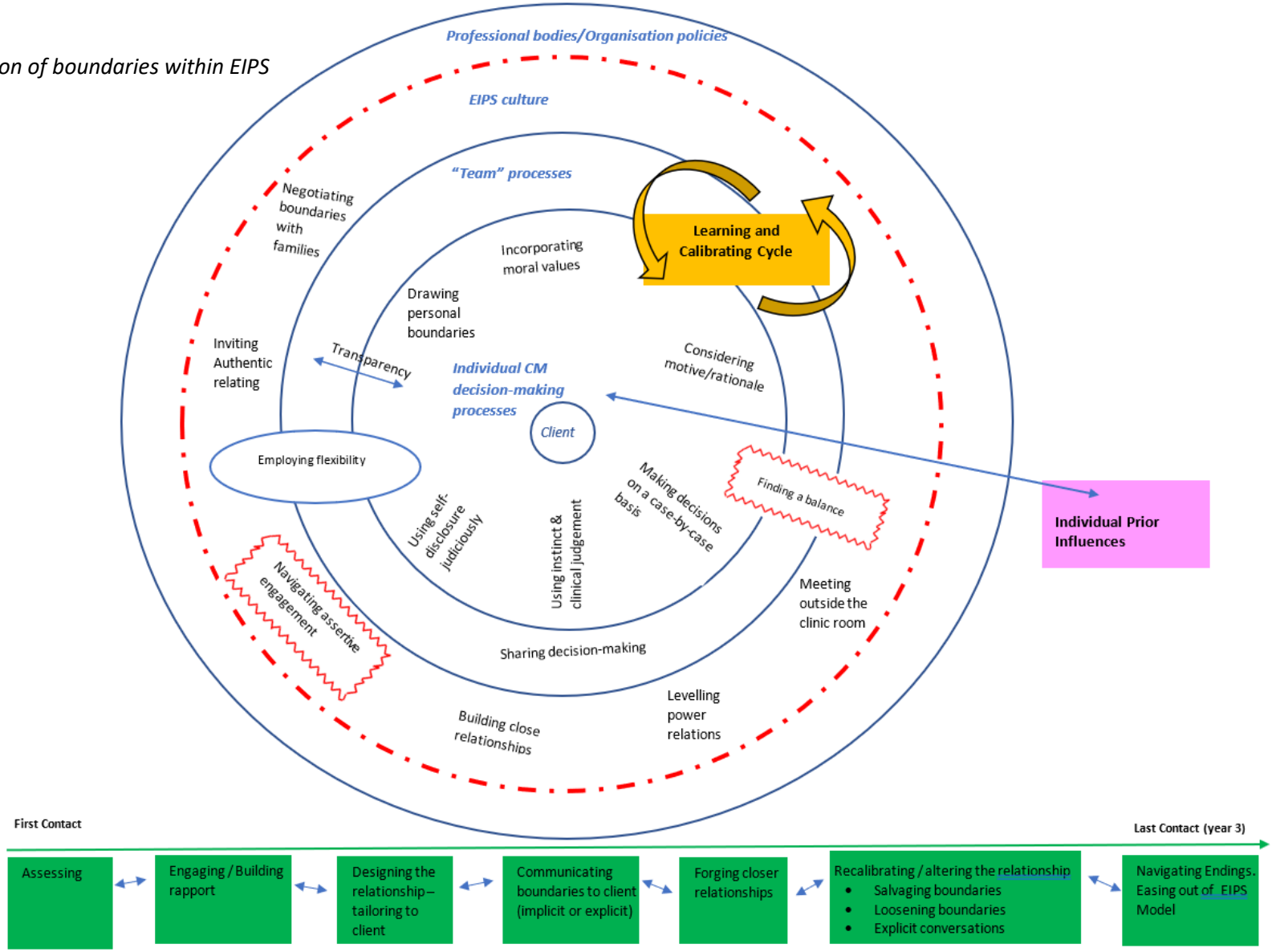
The pink box is positioned outside of the circles, representing CMs' prior experiences or influences which they carried with them into this role. It was clear that CMs' natural, or innate "stance" around boundaries fell somewhere along a spectrum; some CMs tended towards stricter, rigid boundaries, and others tended towards looser, more flexible boundaries. This in turn was influenced by prior experiences, for example during professional training.

Another way of interpreting the data was by conceptualising the CMs' process of navigating boundaries with clients over time (the fixed 3-year timeframe offered by these particular EIPS), and the different challenges arising at different points within this process as boundaries evolved. Therefore, a timeline is presented along the bottom of the model with subcategories outlining the different stages of navigating boundaries. Note, as with the concentric model, this is a dynamic process and there is movement between stages (indicated by arrows), meaning CMs and clients can move back and forth between them.

The model is depicted in figure 3, and outlined in greater detail afterwards with supporting participant quotes.

Figure 3

A model of CMs' navigation of boundaries within EIPS



Findings relating to each layer, and subcategories within these are presented below. Further quotes for all categories can be found in appendix 20.

Professional/Organisational Policy Layer

Participants often began in interviews by referring to their governing bodies' professional codes of conduct, or else organisational policies around boundaries. This represented the highest governing force on how CMs navigated boundaries, and many boundaries were non-negotiable. There was a bottom line which was concerned with participants protecting their own personal safety, and their professional livelihood. "*My job's more important so you've got to have boundaries*" (Participant 1). This could make it tempting to implement black and white boundaries.

Within this attitude, there was sometimes recognition that whilst boundaries were there to protect both clinician and client, CMs could implicitly, or unconsciously hold their own professional boundaries in higher regard than clients' personal boundaries. When clinicians had the ultimate say on where boundaries were drawn, often this was done under the protection of a governing system (e.g., organisational policies), enabling clinicians to absolve some personal responsibility.

Often as the interview progressed, and conversation turned to greyer areas, there was acknowledgement that certain actions or decisions taken around boundaries within EIPS, whilst usually thought through in terms of motives and rationale, (e.g., to engage a client or build rapport) would not necessarily be endorsed by codes of conduct or organisational policies. "*I think some of us…make a bit of a dent in that maybe…When it seems to be the best therapeutic outcome…But it's a dent rather than a break*" (Participant 12).

The perforated red line surrounding the interface between organisational policy and EIPS culture reflects this.

EIPS Culture Layer

This layer represents how the culture within EIPS was a significant influence on how CMs navigated boundaries with clients, and, in itself posed benefits and challenges around navigating boundaries.

Navigating Assertive Engagement

A key tenet of the EIPS model is assertive engagement. Participants discussed being heavily invested in engagement, and the importance of this approach with people experiencing psychosis.

"*some services may say…they didn't turn up…we sent another appointment letter…they didn't turn up…if we were to…strictly stick to that boundary and not assertively go and approach that client in different ways…we would lose fifty percent of our clients…they just wouldn't get a service*" (Participant 11).

However, this sometimes came at a cost of difficulties maintaining either the clinician or the client's boundaries. A tension was navigating the fine line between engaging versus harassing; how to assertively engage whilst respecting client's own boundaries, or when to step back. "*There's been scenarios where…we've made decisions as a team to contact employers…that's a significant boundary to…cross…there's something about the assertive model…that influences how far we encroach on the service-user's boundaries*" (Participant 9).

CMs' individual clinical or personal experiences interacted with how they assertively engaged; sometimes leading to CMs being more inclined to push clients' personal boundaries.

Meeting Outside the Clinic Room

This was a strong feature of EIPS. Meeting outside the clinic room was a means through which many processes related to flexing boundaries or employing flexibility (navigating assertive engagement, levelling power, building close relationships) took place. Most participants expressed the benefits of working in this way, enabling the same "work" to take place in a way which was more flexible, and suited to the client's needs and goals (e.g., going to a café if a client wanted to become

more confident in social situations, or taking exercise together if a client wanted to lose weight). "*I might go for a walk with somebody and I might be doing the same work, but if I sat in a clinic room you would never…be able to work successfully in in that way*" (Participant 10). Some participants also used shared interests as a means to meeting clients (going to the gym, or for a bike ride).

However, meeting outside the clinic room could also raise questions about whether clinicians' boundaries still held precedence when in communal spaces, and often a negotiation, or compromise around boundaries took place.

Levelling Power Relations

All participants either explicitly or implicitly referred to the power dynamics in the client-clinician relationship. EIPS advocates a flattened hierarchy, minimising the inherent power imbalance between clinician and service-user. Flexible boundaries (more tailored to the wants or needs of the client) was a way of levelling power. "*you're trying to minimize that power dynamic as much as you can which means being more flexible with the boundaries*" (Participant 6).

Often participants tried to minimise the power imbalance by taking a collaborative approach with clients, jointly constructing boundaries.

"*having…open conversation about…how do you want that set up?... Be open and honest and transparent about the fact that we need to have boundaries…but actually, how do you find that and what do you want*" (Participant 3)

However, this was often complex in practice. Participants acknowledged that, ultimately, they still held more power, information, and duty of care responsibilities, which they could use to invoke restrictions on client's liberties. Some participants reported experiences whereby clients appeared to value the professional boundaries and responsibilities still present; wanting or expecting the clinician to provide control and safety.

Inviting Authentic Relating

This subcategory was related to using self-disclosure, although encompasses a broader sense of bringing one's authentic, genuine self into clinical work. This often involved expressing their emotions and human responses to clients, which indirectly loosened boundaries. "*Making yourself human and…a real person…just showing that*" (Participant 6).

Participants felt that bringing aspects of their real selves into the relationship invited clients to reciprocate. Some felt if they were not relating authentically with this client group, this led to more traditional "patient-professional" roles and boundaries, in which the client did not meaningfully engage. "*I'm asking them about their kids…their life…to share it in…intimate detail and if I'm not prepared to…be a human as well who has similar experiences…it just feels a bit disingenuous*" (Participant 7).

Building Close Relationships

Due to the intensive nature of EIPS treatment, participants spoke about building closer relationships with clients; being part of their recovery journeys and personal growth. This was linked with the notion of standing alongside clients, positioning themselves as an ally or supporter.

"*we've been on a journey here…I've seen you grow…a couple…they were street homeless…we've been able to support them with housing and, employment and, getting their driving licence back*" (Participant 9).

Closer relationships meant participants could struggle with implementing boundaries when they had a naturally strong alliance with a client. This reflected the fine line between being a supporter versus a friend, and was complicated by use of more informal communication methods, such as texting or WhatsApp.. *"It's kind of what you would do with your mates…we're a little bit maybe more relaxed about what we're actually saying and sharing and how often you're communicating and texting on WhatsApp"* (Participant 8). This concern was particularly present when clients did not have any other support or social networks around them.

Participants spoke about remaining cognisant of professional boundaries, whilst still allowing for a rapport. However, there was a sense for some participants that even if they felt they had drawn the boundary successfully between friend and supporter, they could still not always control how the client perceived (or wanted to perceive) them. *"if I'm in somebody's life in a professional capacity for three years and they feel that they want to share a lot with me…the boundaries may be blurred for them…even if I feel I'm managing it*" (Participant 5)

Negotiating Boundaries with Families

There could be tension in managing concerned families' expectations of boundaries, and marrying this with the assertive engagement way of working in EIPS. "*it's quite hard I think sometimes to explain to parents about building rapport…parents might expect you to go in and sit there with that clipboard and be seen by them to be doing something that's very…medical model focused*" (Participant 1)

As a result of becoming involved in many aspects of clients' lives, and CMs often undertaking family interventions (FI) as well as individual work, determining where to draw the boundaries around confidentiality and how much to share with family members was a challenge. Sharing information could be helpful for families, but have repercussions for clients in feeling as though their personal boundaries had been overlooked.

Sometimes, this challenge extended to boundaries around information-sharing within the team, and balancing this with the realities of families' lives.

"*boundaries put in place…I'm gonna work with him and you work with the brother…to the extent where when one of them is being discussed…other people leave so that they don't hear…although that might be a safer way of working…that's just also not reflective of…how those families are experiencing their lives together*" (Participant 6).

Team Processes Layer

Sharing Decision-making

All participants spoke about the culture of using the "*team brain*" (participant 9) in EIPS when facing boundary quandaries. Dilemmas were discussed with the team, different perspectives offered, and decision-making was shared. "*it's really helpful in our team having…peer workers…drawing on them…if I were to…push this boundary a bit…do you have any thoughts…how that might impact the…patient or the family*?" (Participant 9). Where opinions differed on how to navigate a boundary, a middle ground was reached in which everyone (especially the CM) could feel reasonably comfortable.

If a clinical decision was made that it would not be appropriate to have explicit conversations with clients around boundaries (perhaps not well-received or understood by a client), more active collaboration with colleagues and support would occur; for example, involving a co-worker to reduce level of risk or discomfort for the CM, or, to prevent a client becoming too attached to a CM, or vice versa.

"you take it to the team and say, "ooh how, how do I manage this?" …they'll say…" why don't we introduce someone else in the team"…or "why don't you have a conversation about it…make that explicit" (Participant 6)

Individual Decision-making Layer

This layer refers to the day-to-day, or moment-by-moment decisions around boundaries participants made at an individual level, and the factors they considered in their boundary practice with clients.

Making Decisions on a Case-By-Case Basis

How participants "designed" boundaries with clients was decided on a case-by-case basis, considering idiosyncratic factors (e.g. attachment style, level of engagement or risk) and circumstances. "*it's based on circumstances…I wouldn't be offering to do everybody's washing…unique scenarios call for unique thinking*" (Participant 12).

Many participants expressed the cognitive and emotional burden of making boundary decisions on a case-by-case basis, instead of having blanket rules.

Using Clinical Judgement/Instinct

Participants used their clinical judgement when making boundary decisions. This was often guided by an instinctive, gut feeling. However, there was recognition that occasionally a boundary crossing may feel uncomfortable, but still be the best option. Attention was paid to the safest way it could be crossed.

"*If something doesn't feel quite right, then it probably isn't…even if it's not quite right, does it still need to happen, and what would be the consequences?"* (Participant 12).

Considering Motive/ Rationale

Participants emphasised the importance of considering their rationale, or underlying motive behind making boundary decisions; ensuring their motive was for the client, not themselves. Attention was also paid to the client's motive or needs.

"*In…shifting the boundary, is this gonna be therapeutic? Is this going to be helpful? And…who's it for?...Is it for me? or is it for them*?" (Participant 9)

Using Self-Disclosure Judiciously

CMs were more likely to self-disclose within the EIPS culture.

"*you're sitting in a car…I might have had a chat about…things I might do like going for a run…or…they'll say "oh did you go out"…you end up saying those things and thinking…did I really want to give that much information away…But…actually that's been helpful to that person*" (Participant 3)

Often self-disclosures were done for therapeutic benefit (e.g. normalising) although there were also reasons not to self-disclose (e.g. avoiding burdening the client). A general rule of thumb was: how helpful versus unhelpful would it be for them to know this information?

Concerning personal questions, participants sometimes explored the meaning or purpose behind the question, or responded in vague terms, or with humorous deflective answers, which allowed for authentic relating whilst maintaining boundaries. Participants were also wary of "feeding in" to overvalued ideas or delusional belief systems.

Drawing Personal Boundaries

In addition to the higher governing layers, and EIPS culture, participants drew their own personal boundaries. This could include preferences regarding who they worked with relating to boundaries, or "lines" which they would never cross, even if it were professionally permissible. "*People are allowed to receive gifts up to…quite…a high limit. I personally don't agree with that…So that would be against my own personal boundaries*" (Participant 12)

Incorporating Moral/Ethical Values

Participants incorporated their own moral/ethical values when making boundary decisions, sometimes going beyond the boundaries of their job description to support clients. However, incorporating one's moral values was complicated in greyer areas concerning boundaries; there could be tension between CMs moral compass, and professional/organisational codes of conduct.

"that is…breaking a boundary…On the other hand…morally, would you honestly see…somebody go without food for the sake of a fiver?" (Participant 12).

Processes Transcending Multiple layers

The following section describes processes which transcended multiple layers within the model.

Employing Flexibility

Decisions around flexing boundaries were made by individuals, but thinking creatively and flexibly was encouraged and supported within teams (e.g., ensuring a buddy system if meeting a client outside of work hours), and by EIPS culture.

All participants described employing flexibility with their boundaries, and the necessity of this when working with clients experiencing psychosis to facilitate engagement. "*you're…drawing on every possible avenue for engagement with that person…that…requires you to think quite creatively and flexibly about how you're gonna work with somebody*" (Participant 9)

Common ways in which boundaries were flexed included: timings of meetings (during clients' lunch breaks or after they finished work), communication methods, being creative in where participants met with clients and what they did together, which was often aligned to clients' personal goals.

"*I'm usually happy to do what the client wants…with regards to how we communicate in the best way that suits them…you've got to be quite flexible in this service. Not everybody wants to…or is able to talk on the phone*" (Participant 5)

Employing flexibility around boundaries involved a higher level of cognitive burden for participants, as they were constantly assessing and reassessing the boundaries; judging whether they had got the balance right.

Transparency

Clinicians aimed for a transparent and empathic approach with clients concerning boundaries, particularly when boundary issues arose. Transparency was an important culture within these EIPS teams; most participants spoke about being honest about their client interactions, and discussing boundary dilemmas with the team. This related to broader team processes around joint working, shared decision-making, and consulting colleagues.

"*you're being so transparent…we…check in so often about how we're working with people…No one's kind of holding secretly to well this is what I do with my patient*" (Participant 6)

Several participants could recall or conceive of instances where they were not entirely open with the team regarding boundary dilemmas. However, because this was an exception to the norm, it signalled to them a warning that they had perhaps crossed too far over a boundary.

Finding a Balance

An undercurrent running through all participants' interviews was finding a balance when navigating boundaries. There were multiple balances to be struck, but most fell within three key tensions around boundaries:

- balancing demonstrating authenticity and humanness with professionalism,
- balancing flexibility in boundaries or levelling power with professionalism
- balancing clients' rights and personal boundaries with assertive engagement, or duty of care/safeguarding duties.

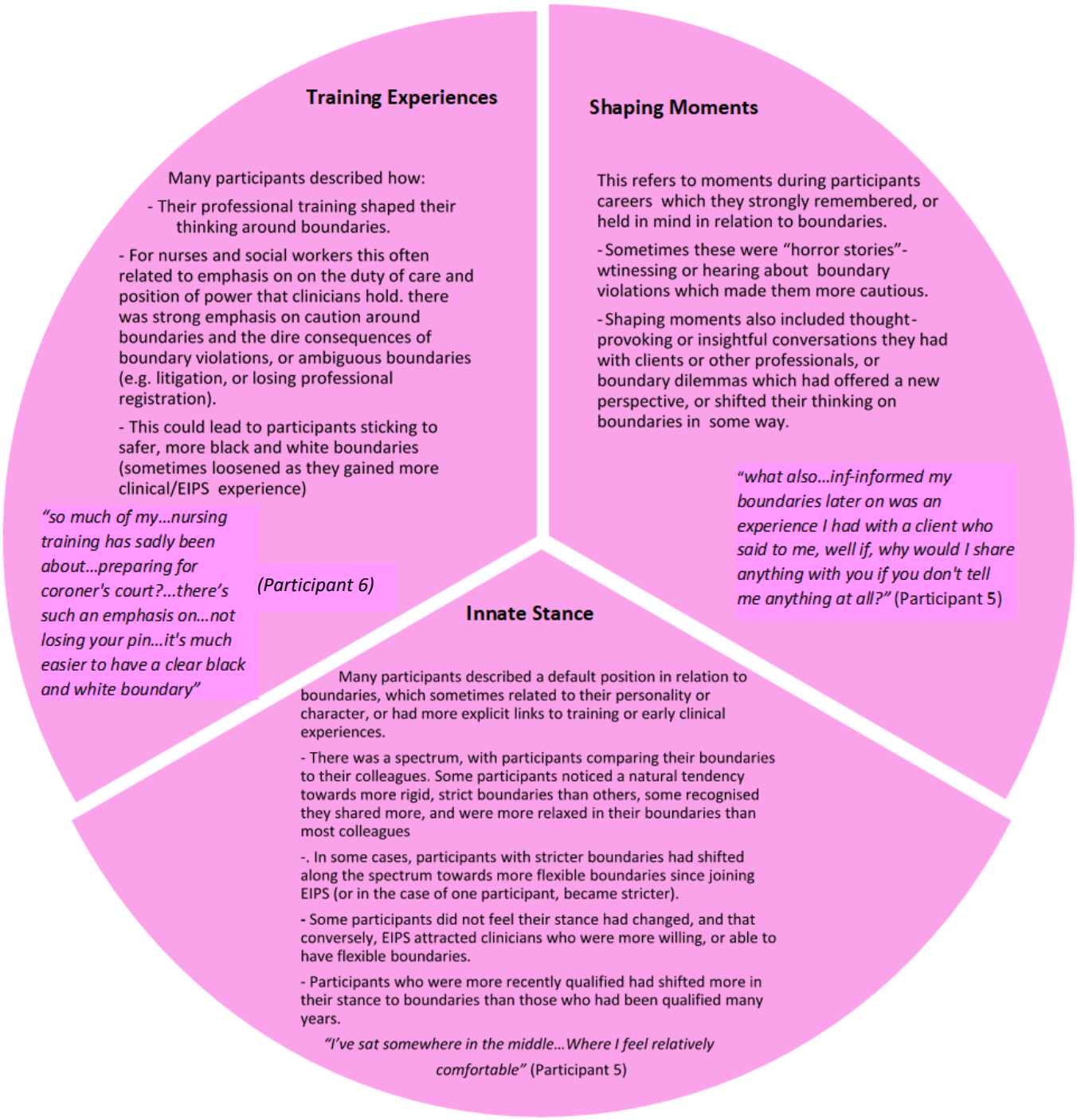
"*one of his goals…is to gain weight….So we started going to…cafes…getting a bite to eat…recently he said…I might get a beer…I'm sort of thinking…that's overstepping some sort of boundary…but then equally it's his life…and if he wants to get a beer...is it my place to be saying…you shouldn't be drinking alcohol when you're meeting up with me as a professional...this person's…living out in the community…they're able to make those decisions…they've got that capacity…I said…it'd be nice to catch up with a clear head…but…I'll leave that decision up to you. And he said…"I'll just have a half then"* (Participant 9).

Individual Prior Influences

Participants perspective on boundaries, or positioning along the boundary "spectrum" was influenced by previous experiences prior to working in EIPS. Figure 4 outlines the predominant influences.

Figure 4

Individual prior influences



Navigating Boundaries Over Time

Another dimension present within the data was participants' process of navigating boundaries with clients over time. Within the EIPS three-year timeframe, many participants felt they

had time to focus on engagement and establish rapport, with boundaries taking a backseat initially. However, participants were also aware of the time-limited nature of their relationship with clients, and sufficiently preparing the client for endings. Patterns were discernible, and Figure 5 presents the common stages in the process of navigating boundaries with clients. In reality this was a dynamic, not necessarily linear process; participants could move back and forth along these stages with clients. More information relating to the time-line can be found in appendix 22.

"that's what's great about early intervention…there is a beginning, middle and end…Amongst that three years…we do have that time…to get to know people at their pace and allow them to…establish their boundaries as time goes on." (Participant 9)

Figure 5

Process of navigating boundaries over EIPS timeframe

Discussion

This research has generated an original model conceptualising the navigation of boundaries within EIPS. It has highlighted how CMs navigate and design boundaries with clients using a flexible, case-by-case approach, which varies over the course of the EIPS timeframe. The benefits of this approach were that CMs were able to present their authentic selves and work within their own moral principles, build meaningful relationships, and better support client-centred, goal-oriented recovery for clients experiencing high levels of distress. This was facilitated by features of EIPS culture, and team processes. Challenges were overcome through consultation with the team or colleagues, with shared decision-making, reflection, and collaboration around boundary decisions, meaning clinicians felt supported holding this complexity. This scaffolded participants' learning and confidence in their own clinical practice, enabling them to navigate boundaries in this nuanced fashion.

Participants in respondent validation interviews recognised the value of this model as a clinical tool to guide CMs' thinking when making difficult boundary decisions, and for reflection around boundaries, both on an individual basis and within teams. This model adds to existing boundary theory, by providing the first conceptualisation of how clinicians navigate boundaries within the unique service model and client group of EIPS. The model also fits with the concept of, and theory around boundary crossings more generally (Gutheil & Gabbard, 1998), which suggests that broad guidelines and principles are helpful (such as professional codes of conduct, or principles such as considering the motive for a boundary crossing). However, the justification for, and impact of a boundary crossing (including whether it becomes a boundary violation) can only be assessed through careful attention to the clinical context, and idiosyncratic circumstances (Gutheil & Gabbard, 1998).

Pertinent challenges to navigating boundaries within EIPS will now be discussed. The EIPS feature of meeting outside of the clinic room, and the looser boundaries this usually entailed raised interesting points around levelling power. Many participants felt that environment had an impact

upon power dynamics, boundaries, and who sets the rules. When meeting clients in their homes, clients' ownership over this space increased their power regarding boundary setting. They could set their own rules (e.g., requesting that CMs remove their shoes) in a manner which they could not have done within a clinic room. This could be an area in which CMs could draw on experience from FI practitioners, as similar features likely apply within FI for psychosis (which often takes place in clients' homes) (Grácio et al., 2016).

This question about who sets the boundaries, and holds power in certain contexts, was further complicated when participants met with clients in public spaces, as they frequently did. Participants described dilemmas of how, or whether, traditional boundaries could hold in communal spaces, particularly in the context of levelling power. For example, a client and a CM having lunch in a café which serves alcohol: does the CM still have the right to set the boundaries and wield power? Dictating to a client (who has mental capacity) the choices they make within that public setting, such as not to drink a beer during their meeting (which arguably greatly alters the frame and tone of the meeting). Sometimes in such scenarios a negotiation or balance was struck, in which the participant would convey the preferred boundaries and reasoning for this, but not categorically impose these.

This was reflective of the broader principles of employing flexibility, and finding a balance, which CMs used in their everyday navigation of boundaries in EIPS. There was a line however, beyond which more traditional professional boundaries were enforced. Where this line was drawn was dependent on factors such as the "greyness" of the scenario, the individual clinician, and the fragility of the engagement or relationship.

This research raised interesting questions around whose interests or agenda were prioritised. Some participants recognised that their professional boundaries or responsibilities were, perhaps unconsciously, held in higher regard than their clients' personal boundaries. At times this was justified under current legal frameworks, for instance if there were legitimate grounds for safeguarding concerns, visiting clients unannounced, or activating legal processes against a client's wishes (such as a mental health act assessment). However, many participants acknowledged

occasions where clients had felt that under the guise of assertive engagement, or offering holistic support, their personal boundaries had been, at best, encroached upon, or at worst, disrespected, without significant cause for concern but simply because they did not wish to engage with the service. Engagement was a key focus for participants, and assertive engagement was often the guiding principle behind why, and to what degree, boundaries were flexed.

Farrelly and Lester's review (2014) found a similar key focus on engagement as the goal, and the problematic aspects of this, for example leading to the assumption that clients should engage with services at all times, and "disengagement" portrayed as problematic. Client studies reported this could come at the cost of their own choices, or personal boundaries being overridden, with detrimental impacts on their self-determination and independence. Although there were similar findings in this research, a key difference was many participants recognised this danger, having listened to clients, and learnt from such experiences. There was therefore caution in not disrespecting clients' own boundaries, although knowing where to draw the boundary with assertive engagement or duty of care responsibilities was still a challenge.

Some participants collaborated with clients to jointly construct appropriate boundaries, understanding where clients drew their personal boundaries. The relationship between engagement and boundaries is reflected in wider mental health research; Gardner & McCutcheon (2015) found that for mental health clinicians, the establishment and maintenance of the professional boundary was inextricably linked to the continual social process of engaging the client. Similar findings have been observed in forensic settings (Aiyegbusi & Kelly, 2012).

Another parallel finding with Farrelly and Lester's review was the dilemma regarding the boundary between supporter and friend. Many of the studies included in the review reported clients expecting clinicians to develop friendships with them: sharing aspects of their personal lives and replacing missing social contact in the clients' lives; findings mirrored in this research. Clinicians in these studies acknowledged this perception, and did not always challenge it, believing this perception of the relationship to have therapeutic benefits for the client. However, they avoided

perceiving the relationship in these terms themselves, feeling this violated their professional boundaries. Similarly in this research, most participants viewed themselves as a supporter rather than a friend in order to maintain professional boundaries, although the nature of the relaxed boundaries made this pull towards friendship or other forms of relating (such as mothering) harder to resist when CMs had good relationships with clients. Whilst participants usually explicitly implemented boundaries when a client's request for friendship or overstepping a boundary was obvious, when this was done in more subtle ways it felt more difficult to navigate, and participants often responded in more subtle ways too, drawing boundaries more implicitly.

Limitations of this Research

Participants were only recruited from one NHS trust. Whilst different teams undoubtably had their own histories and micro-cultures, the EIPS service provision was the same across the trust, and it is possible that small differences in EIPS culture within this trust, or other factors such as the broader trust culture, or the demographic populations in these areas could have also impacted on how CMs navigated boundaries. Given that all teams were accredited by the EIPN (indicating they were adhering to similar standards and style of working), findings are likely to be applicable to other accredited EIPS in the UK. However, it would still be of interest to see if such factors influenced findings, and whether results would be replicated in other trusts and geographical areas.

Similarly, whilst there were similarities between the sample and the wider workforce in terms of age, gender, ethnicity, and qualified experience (Marangozov et al., 2017), most participants were predominantly White-British. This is not reflective of the clinical population accessing EIPS, where there is a disproportionately high number of clients from ethnic minority groups, particularly Black males (Gov.uk, 2017) (likely due to social factors, including discrimination and institutional racism (Fernando, 2017; Metzl, 2009)). In light of this, whether CMs' navigation of boundaries would be influenced by a shared ethnicity with clients was a point several participants touched upon, as a form of inadvertent self-disclosure that could aid therapeutic alliance.

Unfortunately, the researcher was unable to recruit more participants from ethnically diverse backgrounds to explore this question further.

Clinical Implications

A minority of participants sought permission from the client before a potential boundary crossing, for instance permission to self-disclose, or hug the client. This could be an important implication in clinical practice, along with undertaking a collaborative approach to boundary setting: jointly constructing appropriate boundaries in order to understand and respect clients' personal boundaries. These clinical implications are supported by Gutheil and Gabbard (1998) who note that the difference between a violation or a crossing may, sometimes, lie in whether it can be discussed within the therapeutic relationship, or whether permission is first sought for the boundary crossing. Another relevant implication for clinical practice was that participants reported apologising in instances where clients felt they had overstepped their personal boundaries. On these occasions reparation of the therapeutic relationship was often possible, and this is reflective of Gutheil and Gabbard's (1998) notion that boundary crossings or violations can be undone, and appropriate boundaries reinstated through further consideration and discussion with clients (and, if relevant, a clinician apology).

Findings linked to the notion that different mental healthcare professions may have different perspectives on, and challenges around boundaries (Scott, 2011; Valente, 2017). Particularly for participants who were mental health nurses, their clinical practice around boundaries had been shaped by their training, and the saliency of the dire consequences of boundary violations. This, for some, led to an initial preference for clear, rigid boundaries to negate any potential risk. An important application to clinical practice was the utility of liaising with other professions, such as psychologists or peer support workers, who provided different perspectives on boundaries; encouraging participants to consider their underlying motives, or offering useful insights into the client's viewpoint (Davidson et al., 2012).

More generally, this research highlighted the importance of consulting, discussing and

collaborating with colleagues when navigating boundary dilemmas and reflecting on their clinical practice around boundaries. These processes not only took place within formal structures, such as team meetings and supervision, but also through informal, "watercooler" conversations, as and when people needed to discuss dilemmas. Several participants spoke about the loss of this aspect whilst working remotely during COVID-19. This loss might be particularly felt, given the additional cognitive and emotional burden which CMs experienced in EIPS because of the case-by-case, almost meeting-by-meeting, decision-making process around boundaries. The impact of this loss in day-to-day clinical practice around boundaries should therefore be considered, and, if remote working is likely to become a greater feature of CMs' practise in future, how this could be mitigated.

Possible solutions could involve setting up peer supervision or reflective practice spaces online for CMs, or a buddy system, pairing CMs with another clinician. This could serve multiple functions (such as checking in safe with one another at the end of the day), and be a resource for informal discussion and reflection around boundaries as and when needed (rather than having to wait for an appropriate team space, or supervision).

Future Research

There were limitations to recruiting from within one NHS trust, and future research could investigate whether findings are replicable to EIPS in other trusts and geographical areas. Further research could also use a quantitative methodology to examine whether employing more flexible boundaries has any relationship to clinical outcomes (e.g., "symptom" or social recovery, rates of disengagement).

Findings suggested a possible relationship between clients with more "positive symptoms" (e.g., unusual experiences or belief systems), and the impact on how CMs navigated boundaries (feeling a greater protection over clients' personal boundaries, assertively engaging more, or self-disclosing less). These relationships were complex, and further research could explore them in greater depth.

Most importantly, future research could examine the navigation of boundaries within EIPS from the client's perspective; what is helpful or unhelpful regarding how CMs navigate boundaries with them in EIPS, and further exploring strands around who boundaries are for, and how clients' personal boundaries are understood within this model.

Conclusion

This study aimed to better understand how CMs in EIPS develop their understanding and practice around navigating boundaries, given the unique service model and client group. Using GT, a concentric circular model emerged, defining different layers of influence impacting CMs' navigation of boundaries. This included factors specific to EIPS culture, and how CMs develop and navigate boundaries with clients over time within EIPS. Navigating boundaries within EIPS context was a dynamic process, and involved a number of complex challenges. A flexible, case-by-case approach was adopted in response to such challenges. These findings link to the concept of boundary crossings, and further the literature regarding boundary theory outside of therapy contexts. They also link to previous research regarding therapeutic relationships between clients experiencing psychosis and mental health clinicians, and provide more clarity concerning the navigation of boundaries with clients experiencing psychosis in community case-management settings. Findings suggest clinical implications for how CMs can jointly construct appropriate boundaries with clients, and discuss dilemmas using the team as a resource. The model created can be used as a tool in clinical practice to guide clinicians' thinking and reflection around boundaries within EIPS.

References

Aiyegbusi, A. & Kelly, G. (2012). *Professional and therapeutic boundaries in forensic mental health practice*. Jessica Kingsley Publishers

Anderson, K. K., Fuhrer, R., & Malla, A. K. (2010). The pathways to mental health care of first-episode psychosis patients: a systematic review. *Psychological medicine*, *40*(10), 1585-1597. https://doi.org/10.1017/S0033291710000371

Aravind, V.K., Krishnaram, V.D. & Thasneem, Z. (2012). Boundary crossings and violations in clinical settings. *Indian Journal of Psychological Medicine*, 34(1), 21-24. https://doi:10.4103/0253-7176.96151

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research*, *15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Birchwood, M., Lester, H., McCarthy, L., Jones, P., Fowler, D., Amos, T., Freemantle, N., Sharma, V., Lavis, A., Singh, S. and Marshall, M. (2014), National EDEN study design. *Early Intervention in Psychiatry, 8*(1), 59-67. https://doi.org/10.1111/eip.12007

Charmaz, K. (2014). *Constructing grounded theory*. sage.

Clarke, A.E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. sage

Corbin, J.M. (2009). Taking an analytic journey. In J.M. Morse, P.N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A.E. Clarke. *Developing grounded theory: The second generation* (pp. 35-53). Left Coast Press.

Davidson, L., Bellamy, C., Guy, K. & Miller, R (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World psychiatry*, *11*(2), 123-128. https://dx.doi.org/10.1016%2Fj.wpsyc.2012.05.009

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. San Diego, CA: Academic Press.

Doyle, R., Turner, N., Fanning, F., Brennan, D., Renwick, L., Lawlor, E., & Clarke, M. (2014). First-episode psychosis and disengagement from treatment: a systematic review. *Psychiatric Services*, *65*(5), 603-611. https://doi.org/10.1176/appi.ps.201200570

Early intervention in Psychosis Network (2018). Chandra, A., Patterson, E., & Hodge, S. (Eds). *Standards for Early Intervention in Psychosis Services -1st Edition*. Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/early-intervention-in-psychosis-teams-(eipn)/epin-standards-first-edition.pdf?sfvrsn=fd9b4a0f_2

Elliot, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215-229. https://doi.org/10.1348/014466599162782

Elliot, N., & Lazenbatt, A. (2005). How to recognise a 'quality' grounded theory research study. *The Australian journal of advanced nursing 22*(3), 48–52. https://www.ajan.com.au/archive/Vol22/Vol22.3-8.pdf

Farrelly, S., & Lester, H. (2014). Therapeutic relationships between mental health service users with psychotic disorders and their clinicians: a critical interpretive synthesis. *Health & social care in the community, 22*(5), 449-460. https://doi.org/10.1111/hsc.12090

Fernando, S. (2017) *Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health*. Palgrave Macmillan.

Gardner, A., & McCutcheon, H. (2015). A constructivist grounded theory study of mental health clinicians' boundary maintenance. *Australian Nursing and Midwifery Journal, 23*(6), 30-33. https://www.researchgate.net/publication/289702819_Discovering_Constructivist_Grounde

d_Theory's_fit_and_relevance_to_researching_contemporary_mental_health_nursing_practice

Garety, P. A., Craig, T. K., Dunn, G., Fornells-Ambrojo, M., Colbert, S., Rahaman, N., Reed, J., & Power, P. (2006). Specialised care for early psychosis: symptoms, social functioning and patient satisfaction: randomised controlled trial. *The British Journal of Psychiatry, 188*(1), 37-45. https://doi.org/10.1192/bjp.bp.104.007286

Glaser, B. G. (1978*). Theoretical Sensitivity: Advances in the Methodology of Grounded Theory.* Sociology Press.

Glaser, B., & Strauss, A. (1967*). The discovery of grounded theory. strategies for qualitative research*. Aldine.

Gov.UK. Ethnicity Facts and figures. (2021). *Psychotic disorders*. https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-a-psychotic-disorder/latest#title

Grácio, J., Gonçalves-Pereira, M., & Leff, J. (2016). What do we know about family interventions for psychosis at the process level? A systematic review. *Family process*, *55*(1), 79-90. https://doi.org/10.1111/famp.12155

Greenwood K, Chandler R, Labuschagne K, De-Visser R, Peters E, Field A, Garety, P. (2013). Facilitators and barriers to Early Youth Engagement in first episode psychosis services (the EYE project): the subjective experience of engagement of service users, carers and young people. *Schizophrenia Bulletin, 39, (*suppl 1.) http://www.sussexpartnership.nhs.uk/sites/default/files/documents/3._the_eye_project_-_early_youth_engagement_in_first_episode_psychosis_services.pdf

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *The American journal of psychiatry*,*150*(2), 188-196. https://psycnet.apa.org/doi/10.1176/ajp.150.2.188

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *The American Journal of Psychiatry, 155*(3), 409-414. http://hdl.handle.net/10822/912556

Harvey, P. O., Lepage, M., & Malla, A. (2007). Benefits of enriched intervention compared with standard care for patients with recent-onset psychosis: a metaanalytic approach. *The Canadian Journal of Psychiatry*, *52*(7)*,* 464-472. https://doi: 10.1177/070674370705200709

Hinshelwood, R. D. (1999). The difficult patient: The role of 'scientific psychiatry' in understanding patients with chronic schizophrenia or severe personality disorder. The British Journal of Psychiatry, 174(3) 187-190. https://doi.org/10.1192/bjp.174.3.187.

Killaspy, H., White, S., Lalvani, N., Berg, R., Thachil, A., Kallumpuram, S., Nasiruddin, O., Wright, C., & Mezey, G. (2014). The impact of psychosis on social inclusion and associated factors. *International Journal of Social Psychiatry*, *60*(2), 148-154. https://psycnet.apa.org/doi/10.1177/0020764012471918

Kirkbride, J. B., Fearon, P., Morgan, C., Dazzan, P., Morgan, K., Tarrant, J., Lloyd, T., Holloway, J., Hutchinson, G., Leff, J. P., Mallett, R. M., Harrison, G. L., Murray, R. M., & Jones, P. B. (2006). Heterogeneity in incidence rates of schizophrenia and other psychotic syndromes - Findings from the 3-center AESOP study. *Archives of General Psychiatry*, *63*(3), 250 - 258. https://doi.org/10.1001/archpsyc.63.3.250

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage publications.

Marangozov, R., Huxley, C., Manzoni, C., & Pike, G. (2017). *Royal College of Nursing employment survey 2017*. Institute for Employment Studies. https://www.rcn.org.uk/professional-development/publications/pdf-007076

McGorry, P.D., Edwards, J., Mihalopoulos, C., Susan M. Harrigan, S.M., & Henry J. Jackson, H.J. (1996). EPPIC: An Evolving System of Early Detection and Optimal Management. *Schizophrenia Bulletin*, *22*(2). 30-326. https://doi.org/10.1093/schbul/22.2.305

Metzl, J (2009). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press.

Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: making decisions, bypassing blunders, and mending fences. *Journal of clinical psychology, 64*(5), 638–652. https://doi.org/10.1002/jclp.20477

Priebe, S., & McCabe, R. (2006). The therapeutic relationship in psychiatric settings. *Acta Psychiatrica Scandinavica, 113*, 69-72. https://doi.org/10.1111/j.1600-0447.2005.00721.x

Scott, A. (2011). Authenticity work: Mutuality and boundaries in peer support. *Society and Mental Health*, *1*(3), 173-184. https://doi.org/10.1177%2F2156869311431101

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *Journal of the American Academy of Psychiatry and the Law Online, 20*(3), 269-288. http://hdl.handle.net/10822/858063

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice, 26*(5), 499–506. https://doi.org/10.1037/0735-7028.26.5.499

Strauss, A. L. (1987). *Qualitative analysis for social scientists.* Cambridge university press.

Tindall, R.M., Allott, K., Simmons, M., Roberts, W., & Hamilton, B.E. (2018) Engagement at entry to an early intervention service for first episode psychosis: an exploratory study of young

people and caregivers, *Psychosis, 10*(3), 175-186.

https://doi: 10.1080/17522439.2018.1502341

Urquhart, C. (2012). *Grounded theory for qualitative research: A practical guide*. sage.

Valente, S. M. (2017). Managing Professional and Nurse-Patient Relationship Boundaries in Mental Health. *Journal of psychosocial nursing and mental health services*, *55*(1), 45–51. https://doi.org/10.3928/02793695-20170119-09

Williams, J., & Swartz, M. (1998). Treatment boundaries in the case management relationship: A clinical case and discussion. *Community Mental Health Journal, 34*(3), 299-311. https://doi.org/10.1023/A:1018773925938

Wong, H.H., Shahwan, S., Verma, S., & Subramaniam, M. (2019) Case management in early psychosis intervention programme: perspectives of case managers. *Psychosis*, *11*(2), 116-127. https://doi: 10.1080/17522439.2019.1579255

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and health, 15*(2), 215-228. https://doi.org/10.1080/08870440008400302

Section C: Appendices

SALOMONS INSTITUTE

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1: Examples of Use of Therapist Self-Disclosure

The following examples are taken from studies included in the literature review.

Example of negative experiences of TSD around REC issues:

Maxie et al:

One therapist disclosed to an African American couple (in their first couples therapy session) that they could be racist unknowingly, that they hoped this wouldn't happen, but they were watching for this. The couple never returned. (Maxie et al., 2006).

Example of using TSD to acknowledge and validate client's experiences of racism and discrimination

Burkard et al:

A therapist said to their client "I, too, have witnessed several incidents of discrimination on campus, and I have felt upset by these incidents" (Burkard et al., 2006)

Example of using TSD to acknowledge therapists' own shortcomings, blind spots or lack of knowledge

Burkard et al:

In response to a client asking their therapist whether they saw themselves as a racist, the therapist replied, "I have had to struggle with racist feelings and urges, but I am committed to the idea of not behaving in a racist way and trying to overcome any prejudice that I have learned through the culture of my life." (Burkard et al., 2006, p.14).

Example of using humour with TSD to facilitate conversations about REC differences

Maxie et al:

"You didn't expect to see a bald white man, did you?" (Maxie et al., 2006, p. 92)).

Examples of instances when therapists would not use TSD relating to REC

Sunderani and Moodley:

A therapist commented “Saying “no” is often viewed as disrespect …Let’s say I have a young woman, who has moved from Iran with her parents and is struggling with bridging the gap between the culture she is coming from and the oppression she might feel in being a teenager. I wouldn’t share or be inclined to [share] how I stood up to my parents and found my own sexuality. [It] won’t be helpful in her dynamic” (Sunderani & Moodley, 2020, p.750).

Another therapist, when discussing her experiences working with an Indian client experiencing parental issues “it would probably be more compromising for me to share that I no longer talk with my mother …in fact, it probably would have distressed her to think “is that what’s she going to advise me? This is not possible from where I come [as in] for me to eliminate my parents in my life. They’re so integral and they’re so vital” (Sunderani & Moodley, 2020, p. 750).

Use of TSD to normalise experiences and lessen feelings of shame

Bitar et al.:

A client explained “He also endured some of his problems in life. So it made me feel like I wasn’t the only one. He was “Even though I have a degree and I have skills—I have the skills to talk to other people; that doesn’t mean I don’t have problems’” (Bitar et al., 2014, p. 421).

Helpfulness of strategy TSDs

Chang and Berk:

One participant commented that their TSD of strategies “gave me an alternative to what I was doing (and) told me something to try.” (Chang and Berk, 2009, p. 529)

Appendix 2: Critical Appraisal of Studies Using the Mixed Methods Appraisal Tool

Qualitative Studies evaluated using the Mixed Methods Appraisal Tool qualitative checklist

Methodological quality criteria	Study 1: Bitar et al. (2016)	Study 2: Burkard et al. (2006)	Study 3: Chang & Berk (2009)
Clear research questions?	Yes	Yes	Yes
Does the collected data address the research questions?	Yes	Yes	Yes
1.1 Is the qualitative approach appropriate to answer the research question?	Yes-a phenomenological approach is appropriate, as the study seeks to explore the perceptions and experiences of participants.	Yes-CQR is appropriate, as it strives to understand the inner experiences of participants. CQR has also been shown to be a systematic and robust methodology in illuminating psychotherapy processes (Hill et al., 2005).	Yes-study informed by phenomenology and CQR. Phenomenology appropriate as seeking to understand participants individual experiences. CQR as data analysis method was appropriate, as it provides a systematic way of assessing representativeness of key themes across cases-useful for comparing satisfying vs unsatisfying experiences.
1.2 Are the qualitative data collection methods adequate to address the research question?	Yes- Criterion sampling used, and justification for using this within a phenomenological approach is provided. In-depth interview process outlined and interview guide provided-which are appropriate for research question. How interviews were transcribed (and by whom) is not described. Researcher/interviewer was of mixed ethnicity.	Yes-snowballing technique used to recruit so sample may be biased. Interview protocol provided to participants in advance, so possibility for greater social desirability (planning answers). Interview process outlined in detail. Researchers /interviewers documented and discussed their preconceptions/beliefs/ expectations (a form of bracketing) to mitigate bias. Biases outlined. Majority of researchers were European American. They were trained, mock and pilot interviews	Yes-stratified matched pairs design used to isolate factors which predicted satisfaction with cross-racial therapy-selected from a larger pool of potential participants. Resulted in a diverse matched pairs sample. 11 interviewers were from a range of ethnic backgrounds. Supervision and feedback based on interview audiotapes provided to interviewers. Bracketing used by researchers to examine and mitigate bias. Details of biases provided. Interview process outlined in detail-semi-structured interviews appropriate to address research question. Interview schedule provided.

		conducted and interview protocol revised/amended as appropriate. Outline of interview protocol given-appropriate to answer research question, although actual protocol not provided.	Interviewers completed field notes, including observations, process notes, salient themes. Who transcribed interviews is not specified.
1.3 Are the findings adequately derived from the data?	Yes- In-depth description of each step of the data analysis is provided and is-in-keeping with a descriptive phenomenological approach. Peer debriefing was used to minimise researcher bias during analysis (although details of biases not provided). Member checking occurred to ensure accuracy/validity of findings.	Yes-In-depth description of each step of the data analysis, which is in-keeping with CQR. Process of how researchers arrived at a consensus is detailed and is appropriate. Independent auditor was used to review data/decisions made at each stage of data analysis. Stability check used with 2 cases to ensure the data for these cases fitted into the existing categories. However-no respondent validation.	Yes-in depth description of each step of the data analysis, which is in-keeping with CQR. Process of how researchers arrived at a consensus is not outlined in detail. Independent auditor was used to review data/decisions made at each stage of data analysis. Stability check used with 4 cases. Member checking used to ensure credibility of findings.
1.4 Is the interpretation of results sufficiently substantiated by the data?	Yes- quotes are provided to demonstrate each theme- content of quotes well supports the themes.	Yes-quotes provided for most themes although not all. More quotes could also have been given. In place of this a “typical pathway” of TSD was provided, and an extensive illustration/quotes from one participant to demonstrate this pathway. However, no “general frequencies” emerged in categories (i.e., applies to every single participant).	Yes-quotes provided to demonstrate each theme-content of quotes well supports themes. Full list of categories, descriptions and frequency provided as an appendix.
1.5 Is there coherence between qualitative data sources, collection,	Yes-there is coherence between data source, collection, analysis & interpretation. It was stated that data saturation was reached after 10 participants. The primary	Yes-there is coherence between data source, collection, analysis & interpretation. Potential bias in sample, and in participant responses (tending to discuss positive experiences of TSD rather	Yes-there is coherence between data source, collection, analysis & interpretation, although no member checking. It was recognised that the diverse sample, whilst ideal for commonalities, meant there may be group-specific/dyad-specific

analysis and interpretation?	researcher was also a therapist at the mental health agency where participants were recruited. Whilst none of his own clients were recruited and peer debriefing was in place, more comment around researcher reflexivity could have been made.	than negative), and lack of client perspective is acknowledged. "general frequencies" may have emerged with new CQR guidelines (applying to all but one case).	issues which could not be extricated. It was acknowledged that even with bracketing and examining biases throughout all stages of the study, researcher expectations may still have unconsciously influenced understanding and interpretation of the data.

Qualitative Studies evaluated using the MMAT qualitative checklist

Methodological quality criteria	Study 5: Lee (2014)	Study 7: Phiri et al. (2019)	Study 8: Sunderani et al. (2020)	Study 9: Twohey (2004)
Clear research questions?	Yes	Yes	Yes	Yes
Does the collected data address the research questions?	Yes	Yes	Yes	Yes
1.1 Is the qualitative approach appropriate to answer the research question?	Yes-CDA is appropriate in order to analyse power and language within the therapy dyad, and to examine how therapists and clients position themselves in relation to narratives around TSD (e.g., passive/active) and broader socio-political discourses.	Yes-ethnographic informed approach is appropriate, as study relates to cultural behaviours/factors. Justification for using thematic content analysis is provided and appropriate-although acknowledges discourse analysis would have been ideal were it not for the large sample sizes.	Yes-researchers describe their approach as "borrowed" from grounded theory (constant comparison method), with a social constructivist epistemological position. Full grounded theory was not implemented due to the number of cultural and diversity factors, meaning data saturation could	Yes-study based in grounded theory. Whilst intuitively this seems appropriate, explicit rationale for using grounded theory is not given. Interpersonal Process Recall also used with participants after the therapy session-rationale for this provided and is appropriate.

			not be reached with the number of participants available.	
1.2 Are the qualitative data collection methods adequate to address the research question?	Yes-criterion sampling used, first 3 therapy sessions were recorded by therapist and transcribed (who transcribed sessions is not stated). However, for more detail around data collection, reader is referred to a previous paper from the author. No comment made regarding researcher preconceptions/bias, or use of diary/field notes etc for this particular research question/analysis.	Yes-purposive sampling used and appropriate justification for this given. Multiple data sources enabling triangulation of data, enhancing reliability and validity. Semi-structured interviews and focus group processes outlined. Appropriate justification provided for use of focus groups. Field notes taken by researcher during data collection. No other comment regarding researcher preconceptions/biases. Interview guide themes provided.	Yes. Semi-structured interviews are appropriate to address research questions. Detailed outline of interview schedule provided with sample questions which were appropriate (although actual schedule not provided). Ongoing reflective commentary and "debriefing sessions" occurred -little detail given around these, or researcher demographics and background. A third party verified transcripts, and participants were provided with a copy of their transcript to ensure this reflected their viewpoints/ experiences.	Yes-purposive sampling used, although risk of selection bias acknowledged. therapy session is recorded and followed up with IPR review-which is outlined. Topics discussed during therapy session are outlined, and are appropriate. However, an example or appendix with more detail of the IPR interview process would have been a useful addition.
1.3 Are the findings adequately derived from the data?	Yes- description of analysis process provided, although could be more detailed. 2 case vignettes provided to demonstrate analysis and findings. No independent reviewer of data analysis/peer debriefing/comment	Yes-In-depth description of stages of thematic content analysis provided. 3 Independent reviewers analysed a sample of transcripts to check reliability of coding, and interpretation of themes, and compared emerging themes with those of the researchers. Researcher met regularly with	Yes-although application of the constant comparison method could have been described in more detail. It is unclear whether "debriefing sessions" refers to peer debriefing. Ongoing reflective commentary used to acknowledge interviewer reflections/biases although little detail given around this-more	Yes-description of analysis process provided, although could be more detailed. 2 independent reviewers read and analysed an interview, one of whom was American Indian. This reviewer also discussed their reactions to the results with the researcher as a validity check- in place of respondent validation. However, no comment regarding

	around potential researcher bias.	the research team (including researchers from BME groups-enabling "translations" in the data). Data saturation was reached. However, there was no respondent validation.	detail would have been in line with a social constructivist approach. No respondent validation.	primary researcher's own biases/expectations, or use of reflective diaries or bracketing.
1.4 Is the interpretation of results sufficiently substantiated by the data?	Yes-for the data which is presented (both cases focus on instances where TSD has illuminated dominant discourses) however there is little comment around how typical this was of the rest of the data and data analysis.	Partially-quotes were provided for each theme and the content of quotes well supported the themes for clinicians. However, this was less evident for clients-more quotes, and longer/richer quotes from client participants was needed to substantiate reported client findings.	Yes- lengthy and rich quotes provided which effectively support each theme.	Partial-whilst some themes had multiple rich quotes, other themes (generally the smaller themes) had little to no quotes-meaning the interpretation could not be substantiated by the data.
1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?	Partially-there were clear links between data sources, collection, analysis and interpretation. However more detail and explanation around data collection/analysis process, and how findings presented reflected the wider data analysis would have improved coherence.	Yes-there are clear links between data source, collection, analysis & interpretation. More quotes from clients and respondent validation would have increased coherence. Whilst it is mentioned the researcher met regularly with the research team (independent reviewers) any information regarding researcher's own reflexivity/biases would also have enriched this.	Yes, although respondent validation would have increased coherence, and more detail around researcher reflections/biases/debriefing process would have been in line with the social constructivist approach. Acknowledgement of possible participant social desirability bias influencing findings-more positive than negative experiences disclosed.	Yes-although more quotes needed for certain smaller themes for interpretation to be clearly linked to the raw data. There was acknowledgement of potentially higher levels of acculturation or selection bias with participants, leading to a less representative sample. Respondent validation would have enriched data and improved findings.

Quantitative study evaluated using the MMAT quantitative non-randomized studies checklist

Methodological quality criteria	Study 4: Kim et al. (2003)
Are there clear research questions?	Yes
Does the collected data address the research questions?	Yes
3.1 Are the participants representative of the target population?	Partially-inclusion criteria and target population are outlined. 2 factors negatively impacted representativeness of target population: firstly, participants were university students, with an average age of 20. Secondly, the majority of participants were first- or second-generation immigrants. Both of these factors are less representative of the wider Asian-American population.
3.2 Are the measurements appropriate regarding both the outcome and intervention/exposure?	Yes-Variables are clearly defined and accurately measured, and measures are appropriate for the intervention/outcome. Reliability of all measures was adequately demonstrated, with no alpha coefficients reported below.72, and mostly .81 and above for this data, and similarly with internal consistency alpha coefficients. Good evidence of construct validity for measures was obtained through exploratory and then confirmatory factor analysis. Correlations showed good concurrent and discriminant validity. One scale was devised for this study (a single-item intimacy measure), and so psychometric quality could be questioned, however the measure had good face validity, and was modelled on similar single-item measures. Because the 4 DV's were highly correlated, z scores were combined to form an outcome index (internal consistency coefficient alpha .89).
3.3 Are there complete outcome data?	Yes-90.3% of data was included. 6 participants data was omitted (from a sample of 62). 4 participants data was omitted because the therapist did not correctly implement the SD conditions. Data from 2 additional participants was then also excluded so each therapist had undertaken an equal number of high and low SD sessions.
3.4 Are the confounders accounted for in the design and analysis?	Mostly yes-many variables are measured, and the IVs are accounted for in the analysis using a hierarchical multiple regression (with the outcome index as a DV), so confounding bias is relatively low. However, the study acknowledges potential confounding variables which were not measured-particularly adherence to US cultural values, severity of presenting problem, and using session observers.

3.5 During the study period, is the intervention administered/ exposure occurred as intended?	Yes, and administering of intervention was assessed using both therapist and client manipulation checks, which were significant, indicating the intervention was manipulated successfully. (The few exceptions to this were excluded). However, the study acknowledged that due to sample limitations, there was little variability in AVS scores, meaning there was insufficient support for interaction effects between adherence to Asian cultural values and therapist SD on session outcome.

Note: SD= Self-disclosure, IV=Independent variable DV=dependent Variable AVS=Asian Values Scale

Mixed Methods Study evaluated using the MMAT mixed methods checklist

Methodological quality criteria	Study 6: Maxie et al. (2006)
Are there clear research questions?	Yes
Does the collected data address the research questions?	Yes
5.1 Is there an adequate rationale for using a mixed method design to address the research question?	Yes-the survey was mostly quantitative, but open-ended questions included throughout, and a substantial qualitative section at the end with open-ended questions was incorporated in order to provide information to aid in the interpretation of the quantitative survey items.
5.2 Are the different components of the study effectively integrated to answer the research question?	Yes-quantitative and qualitative data was triangulated to provide a complete picture around addressing difference and TSD-e.g., reasons for bringing up difference-quantitative data and qualitative data was interwoven. Qualitative analysis was undertaken prior to quantitative to minimise potential biases from knowing quantitative results. Quantitative and qualitative analysis was integrated during interpretation stage.
5.3 Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes- the quantitative data is corroborated (or further context provided) and made richer through the interpretation of qualitative data, throughout most of the results and discussion, suggesting meta-inference.
5.4 Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Yes- inconsistencies between the quantitative and qualitative data (e.g., Whether or not therapists and clients are equally likely to make SD about differences) are well reported and reconciled.

5.5 Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Mostly yes-qualitative and quantitative criteria met to a similar standard. Some areas where criteria could have been more fully met have been rated as "partial". See next table for the methodological quality criteria for qualitative and quantitative components of the study, respectively

Evaluation of the qualitative and quantitative components of the mixed methods study using the relevant checklists

Methodological quality criteria: 1. Qualitative studies	Study 6: Maxie et al. (2006)
1.1 Is the qualitative approach appropriate to answer the research question?	Partial-whilst using narrative analysis has answered the research question well, it is unclear (and it is not stated) why narrative analysis specifically was chosen over, for example, thematic analysis.
1.2 Are the qualitative data collection methods adequate to address the research question?	Partial- participants were randomly selected, although 40% response rate to the survey so there could be a nonresponse bias. However still a huge sample. Qualitative data collection methods within the survey are clearly outlined and are adequate to address the research questions, although the main qualitative section was an optional part of completing the survey. Data collection would have been better had this not been optional. Advantage of anonymous survey-possibly less social desirability bias, large sample size, disadvantages-cannot ask specific follow-up questions, ask participants to elaborate on points as with interviews.
1.3 Are the findings adequately derived from the data?	Yes- In-depth description of stages of coding/analysis process provided which is suitable. Analysis conducted by two people, but no comment regarding how a consensus was reached in occurrences of disagreement. Additionally, there was no independent reviewer of analysis.
1.4 Is the interpretation of results sufficiently substantiated by the data?	Yes- a large table of quotes is provided with multiple quotes to demonstrate each subtheme- content of quotes well supports the themes/subthemes.

1.5 Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes-there are clear links between data source, collection, analysis & interpretation. However, several factors would have strengthened coherence: a rationale for using narrative analysis in particular; making the main qualitative section of the survey obligatory; using an independent reviewer for analysis. The study acknowledged potential issues with self-reporting, risk of psychologists overestimating/overstating their competencies, or being unaware of blind spots.
Methodological quality criteria 4: Quantitative descriptive studies*	
4.1 Is the sampling strategy relevant to address the research question?	Yes- probability sampling used, involving random selection from an appropriate source for the target population (APA registered psychologists).
4.2 Is the sample representative of the target population?	Yes- demographic/experience/training orientation profile of sample was very similar to that of APA members.
4.3 Are the measurements appropriate?	Partial- survey was pretested with psychology graduate students and faculty members, and revised based on feedback. Further revisions were made following recommendations from APA's research division. Variables are clearly defined and relevant. Most variables appear to be accurately measured, aside from limitations of self-reporting. However, the study acknowledged that some measures were rough measurements (e.g., TSD arose in more or less than half of cross-cultural therapy cases). meaning less precision in analysing relationships between variables. Whilst the quantitative questions asked regarding therapists' experience of working cross-culturally with clients could be discerned from the results section, providing examples of exact questions used in this part of the survey would have been useful in more thoroughly assessing measurement (although the survey was available from authors on request).
4.4 Is the risk of nonresponse bias low?	Partial- 40% response rate, an average to good response rate for such a large-scale survey. However, the majority of participants who responded reported feeling comfortable addressing/discussing differences with clients. This suggests there may be a nonresponse bias for psychologists who feel less confident/comfortable (and as a result may have chosen not to partake in the survey). It is difficult to verify this, and reasons for non-response were not requested.

4.5 Is the statistical analysis appropriate to answer the research question?	Yes- the aims of the descriptive and inferential statistics used is clearly stated, and is appropriate to answer the research questions. A one-way ANOVA revealed therapy models significantly differed in discussions of differences, and after correlations revealed that discussions of differences were related to a number of variables, simultaneous multiple regression was conducted appropriately to examine their independent influences on discussion frequency.

**Whilst this study did employ some inferential statistics, the survey design and methodology fitted better with the quantitative descriptive checklist.*

TSD=Therapist Self-disclosure.

Appendix 3: University Ethical Approval

This has been removed from the electronic copy.

Appendix 4: NHS Health Research Authority Approval

This has been removed from the electronic copy.

Appendix 5: Extracts from Researchers Reflective Diary

Diary entry 06.10.20

I am feeling cautious/worried about "leading" participants at times - e.g. by offering them prompts, using certain words (e.g. negotiate/navigate)-it's hard to know which words participants would have used freely themselves without me "feeding" them anything!

Diary entry 20.10.20

Concerning interviewer automatic assumptions/biases: I found these are "leaking out" at times during the interviews (check whether or not this is ok within interventive interviewing?) I tried to remain alert to these throughout the process. I noticed I am more likely to demonstrate an agreement bias if I agreed with a stance or position a participant was taking (e.g. "mmm definitely") and was generally more careful in remaining neutral/sounding neutral in my responses when there were points/ideas I found myself agreeing less with.

Similarly coding interpretations/reflections I have made-If I have made a reflection back or interpretation on what the participant has said-if they have followed this with "yeah exactly" or "that's right" I have included this code in my analysis -although being mindful of possible social desirability factors with this (i.e. just agreeing/going along with my interpretation). I think this is less likely, as often participants have corrected or expanded if I have not quite hit the mark.

Diary entry-11.11.20

From an interview with one of the participants I knew in my first-year placement. They made comments during the interview like "As you will know"-advantage of being an interviewer coming from a similar background/with similar experience-understanding what participants are talking about. But drawbacks of this-e.g. am I getting caught up in things more easily, finding it harder to be objective, or to step back and see the bigger picture. Also, my profession means I can see how I am coding through a psychology "lens" (which Charmaz acknowledges is to be expected) e.g. ideas like projection or denial or transference.

Diary entry 22.11.20

A lot of my participants so far have not been qualified for very long. I think it would be good to get some participants who have more clinical experience to see how this compares to my analysis of my first "batch" of interviews, and what the similarities and differences are in how they navigate boundaries. I have also only interviewed one male participant so far, who raised some interesting points regarding how they navigate boundaries with perceived vulnerable females, and what they feel comfortable with. This links with an idea/category that is forming about participants' drawing their own comfortable or personal boundaries. I think it would be good theoretical sampling wise to interview some more males to see if there are similarities or differences in how their gender interacts with how they are navigating boundaries.

Diary entry 15.12.20

Just had a thought about the Context of COVID-19, which feels like a "backdrop" to interviews. conducting interviews via video calling has benefits and drawbacks

Benefits- it is providing new insights/knowledge that might not otherwise have been discovered (e.g., seeing what backgrounds participants choose to be interviewed in, discussing these elements)

Drawbacks- conducting the interview feels more clunky (e.g., freezing, talking over one another) and when technology difficulties occur, it feels easy to lose the flow/rhythm of the interview and the conversation.

It feels weird looking back on this research in years to come, it will serve as a little time capsule of what it was like experiencing/adapting to COVID-19 within mental health services!

Diary entry 08.01.21

Several participants have been talking about how inadvertent self-disclosures (e.g., their age, skin colour, being pregnant) affects their boundaries. One participant felt that being white was a disadvantage when working with young black men, who felt they could not trust him because they viewed him as part of an institutionally racist system (of which he'd been part of all his life in various forms, e.g., when he was in school). He felt this affected their therapeutic alliance, and that they needed more diversity within EIPS staff. I just interviewed a participant from a Black British/Caribbean background, and asked them a little about whether they felt being black had any impact on their therapeutic relationships or how they navigated boundaries. They felt whilst it doesn't have any bearing when they are working with white clients, it can lead to a stronger rapport and therapeutic alliance when there is some sense of a shared ethnicity, even if this is not explicitly discussed. If possible, it would be interesting to explore this further with my remaining participants and to look more into whether this has any impact upon boundaries (ideally recruiting some participants from more diverse ethnic backgrounds).

Extracts from reflections following individual interviews

Reflections following Interview 1:

- I felt he was not talking about boundaries in the way I expected/understood boundaries. This made me question my own assumptions/understandings around boundaries, and I realised these may not be shared. Later I realised he has a different take/angle on boundaries compared to all my other participants (more about time management, what is and is not your job role/responsibility). This raised questions around my assumptions/understanding of boundaries (understanding this through a psychology lens?)

-Friendly relationship dynamic/feel to the relationship-could tell we knew each other previously?

-some acknowledgement of prior relationship by participant at points within the interview

-at a later point in the interview, interviewer also made a comment acknowledging prior working relationship with participant (following participants lead on this)

I noticed the participant uses humour a lot-possibly to make difficult issues feel easier, or possibly due to prior working relationship with interviewer?

Reflections following Interview 3:

This participant felt quite thought blocked a lot of the time, struggled to give examples or think of challenges. (Possibly because fairly new to EIS, possibly due to other reasons e.g., participant said they had dyslexia, possibly due to genuinely having few difficulties/experiences with boundaries?)

With this participant however lot of the issues I raised as prompts, arose later within different guises/contexts

Reflections following Interview 7:

I noticed I conveyed an agreement bias on several occasions with this participant-agreeing with a stance or position a participant was taking (e.g., “mmm definitely”).

I noticed contradictions from participant at time over the course of the interview-e.g., in how they say they do things or how they say they would/should go about boundaries with clients. This changing over the course of the interview as they reflect more? e.g., T7-says tends to start with boundaries looser to facilitate engagement, then later when reflecting on an interaction with a client when they first joined, said NOW they would do things differently by starting tighter, then loosening later. Could also be due to individual client differences?

Reflections following Interview 8:

I notice my voice is present a lot in this interview-more than most others. Why is this? Trying to get most out of the participant and their answers? So overcompensating by providing lots of prompts? Or feeling more like an informal conversation rather than an interview?

Noticing lots of contradictions within the interview-representing what she knows is the “correct” answer, and how she actually feels about the relationships?

Reflections following Interview 9:

-felt I got on very well with this participant on a personal level; similar ages between us/stages in careers. Noticed this affinity, also reciprocated/encouraged with her personable style- e.g., calling me by my name at points during the interview

Felt at times I may have slipped slightly out of neutral, interviewer mode?

Reflections following Interview 10**:**

I was conscious of at points in this interview possibly leading the interview questions moreso than I may have done with other participants. I was conscious this is my only participant from a non-white ethnic background, and I wanted to draw this out within the interview if this were possible, but in a way which felt comfortable and not singling out for the participant

Reflections following Interview 11:

This participant felt very open and reflective around the topic-gave me the impression this is something he has thought about and reflected on a lot before.

Reflections following Interview 12:

similarity to several participants-starting from a fixed, “official” position on boundaries, then opening up/becoming more flexible as the interview goes on, and grey areas are worked into e.g., towards the start, focusing on code of conduct as guide for boundaries, then gradually acknowledging/introducing other elements into the decision making. Equally, at the beginning spoke about “breaking” their boundaries, sense of black and white “breaking” of boundaries. By the end of the interview, this perception had shifted/become more nuanced, to “denting” boundaries. Also Reflective of relationship/rapport/trust developing throughout the interview?

I noticed using the term “we” when asking several questions during this interview. Possibly I was using this phrasing to get alongside the participant? Could also suggest I had lost my more objective position? Become too enmeshed with subject matter/participants?

This participant (as with lots of the participants) felt very open and transparent within interview process around errors/mistakes they had made or dilemmas they had faced. Sense of this mirroring openness and transparency culture within the team?

Reflections following interview 13

I noticed the same similarity again - starting from a fixed, quite absolutist position e.g., around boundaries and self-disclosure, and this relaxing or becoming more flexible as the interview goes on, and the grey areas are worked into (as they feel more comfortable in the interview?)

This participant's seniority created an interesting relational dynamic for me as interviewer; I found myself agreeing with him a lot (or siding with him?) This may have been a reflection of the position I placed myself, or felt like I was in with them. On the one hand I feel through doing this research I have gained a lot of knowledge and expertise around boundaries; on the other hand, when it comes to general clinical experience, I felt far less experienced than them. I also had some experience of working with them previously in my first-year placement; again where they were someone I might have turned to for advice and their opinion. I think I felt this dynamic a bit with participant 12 too (of them having far more clinical experience) however, because participant 12 was very forthcoming in reflecting on their own difficulties and dilemmas with boundaries, and questioning whether or not they had got it right, I think I did not notice myself siding with them, or feeling less experienced in quite the same way.

Participant 13 had just returned to EIS after having been on a year secondment in the generic CMHT. This provided a useful angle/perspective in comparison to my other participants. I noticed they were in a position to take a wider, almost outsider perspective look at the EIS model. They had noticed a sense of elitism which could sometimes be present within EIS services (a sense of "our model is the only way/best way to do things") which is something I had picked up on in several of my other interviews too. Having just been on secondment in a pressured and struggling CMHT, they were firstly able to be more empathetic to the pressures and strains being faced by the CMHT, and secondly were in a position to refute some of the common misconceptions about other services which seemed to be present amongst EIS staff (e.g., EIS are the only community service that really texts clients, gives clients their work mobile numbers rather than making them ring duty, etc.). Whilst this may have been the case in the past, this participant was able to acknowledge the changes in practices that have been happening in the past few years, and the innovative ways they too have been practising and communicating with clients. Highlighting this difference made me feel slightly like I was getting a rap on the knuckles- my previous interviews had led me to gather more information about this particular topic and led me to a bit of an assumption that most people felt there WERE big differences or better things about the EIS model-this made me reflect on how I had been asking this question and slight potential bias which may have been present in previous interviews. Although it is difficult as these biases were also part of me following/being guided by the data I was receiving from participants

Appendix 6: Study Overview for EIPS Team Leaders

EIP Lead Practitioner boundaries study: summary of the research project & involvement from EI teams

(Very) brief background

Within the EIS model there is little formal theory or models regarding boundaries; beyond fairly black and white professional codes of conduct or trust policies (particularly for disciplines other than psychology/therapy) that lead practitioners in EIPS can draw on to understand or think about how (and why) boundaries can best be navigated with these service-users within this service model. This study aims to develop a grounded theory to explore the nuances and subtleties of managing boundaries within this unique service model. It will examine how Lead Practitioners (also known as care coordinators or case managers) in Early Intervention in Psychosis services in East Sussex develop their understanding and practice around boundary management, given the inherent challenges (e.g. power imbalance between clinician/service-user, respecting privacy versus assertive engagement approach, drawing the line between supporter/friend), and impact on engagement.

Brief overview of the research project

This qualitative study aims to explore how Lead Practitioners in Early Intervention in Psychosis Services understand and navigate boundaries with service-users. Semi-structured interviews will be conducted with Lead Practitioners (LP)'s in EIP services xxxxxxxxxxxx Trust. Recruitment will continue until theoretical sufficiency in the data is reached, by which we mean it feels as though no 'new information' is being produced, and we have enough data with which to create a 'model', or theory to explain how staff members understand and navigate boundaries with service-users in this service context. However, there is an estimated sample size 12-16 participants. The interview data will be analysed using grounded theory.

What involvement would be required from EI teams?

Short answer:

- Linking in the researcher with LPs in the team. Then, for LPs who are interested in participating, up to an hour of their time to participate in a semi-structured interview with the researcher.

Further details:

Recruitment

- Team leaders of EIP teams would be sent an email by either the researcher and/or Becky Whitfield (study external supervisor), outlining the study and the requirement from Lead Practitioners. This email would also request a convenient team meeting/time slot that the researcher could speak to each team about the study.
- The original plan was for the researcher to visit EI teams in person to talk to them about the study, and to provide them with an information sheet. If any LPs at this stage knew they would like to participate, email addresses could then be taken from these participants and the researcher could follow up with them directly.
- However, if, due to COVID-19 restrictions, it is decided that the researcher should not visit team meetings in person, ideally the researcher would join a team meeting via video call to talk to teams about the study, and the team leader would forward the information sheet to all lead practitioners in their team. Those who expressed interest at this stage could be followed up by the researcher to arrange a convenient time/place (if applicable) to undertake the consent form

and interview. This may involve team leaders emailing the researcher with a list of names/email addresses of all those who expressed interest-depending on how easy it is to collate this information during a video call!

- After this, there would only be the need for further involvement from team leaders if the researcher is struggling to recruit, in which case team leaders reminding lead practitioners of the study, or possibly even the researcher visiting another team meeting (either virtually or in person) may be required.

Study involvement

- The original plan was for the researcher to visit LPs at (name of trust) site convenient to the LP (and where participant and researcher can remain 2 metres apart) to conduct the interview. However, during COVID-19 restrictions, if preferred by participants or stipulated as a necessary requirement for study go-ahead, interviews could take place via Zoom instead.
- Interviews would last no more than an hour (more likely 30/40 mins max). Whether interviews with LPs were conducted during working hours, or during lunch break/outside of working hours is a decision the leadership team (or individual team leaders) could make.
- Estimated sample size of around 12-16 participants
- Participants will have the option to be involved in respondent validation during analysis of the interview data. This involves the researcher showing the participant their qualitative analysis, and emerging themes/theory. Participants would have the option to comment and provide reflections on this, the aim being to ensure that the data has been well interpreted. This could again occur face to face, or via a Zoom call. However, this part of the process is voluntary.

Study findings

- Study findings will of course be fed back to EI teams and participants in the form of a brief summary report, and a longer report providing more detail of the findings.
- There will be the option for participants/teams to have findings fed back in person, for instance by visiting another team meeting, should teams be interested in this.
- The project will also be published in a relevant journal and presented at relevant conferences/trust research department.

Study Research questions

The research questions the study is investigating (and will be included in more detail in the interview) include:

- What do LPs understand by the concept of 'boundaries'?
- How do they define the term/what do they think is the point of them?
- How do they navigate boundaries with service-users in their clinical practice?
- What has informed their decision making?
- What are the benefits and particular challenges around boundaries that LPs face in EIP services? How do they overcome these challenges?
- How might LPs' approach to boundaries relate to engagement of their service users with them, and with the service?
- How does their approach to boundaries compare with the approaches of their colleagues?

  (Last 2 questions added following consultation with Kathy Greenwood, to tie in more with the EYE project.)

Appendix 7: Participant Information Sheet

Participant Information Sheet

'A Grounded Theory study exploring how staff understand and navigate boundaries in Early Intervention in Psychosis Services'

My name is Alexandra Bone, and I am a trainee clinical psychologist at Salomons Insititute for Applied Psychology (part of Canterbury Christchurch University). I would like to invite you to take part in my research study. My research study is being supervised by Dr Rachel Terry (Clinical and Academic Tutor, Salomons Institute for Applied Psychology), and Dr Becky Whitfield (Counselling Psychologist & systemic practitioner, xxxxxxxx Early Intervention service).

Before you decide whether or not you would like to take part, it is important that you understand why the research is being done and what it would involve for you.

Part 1 tells you the purpose of this study and what would be involved if you choose to take part. Part 2 gives you more detailed information about the conduct of the study, if you think you might like to take part.

Information Sheet: Part 1

What is the purpose of the study?

The term 'professional boundaries' refers to the psychological, social, emotional, and physical space between the staff and the client, and keeping relationships between staff and clients appropriate and safe. This is a complex issue, however there is little formal guidance or theory around managing boundaries and therefore navigating ideal boundaries appears to be a rather subjective experience. This study is interested in your thoughts, experiences and clinical practice around navigating boundaries in early intervention in psychosis services, and how these have developed. These first hand perspectives and experiences can hopefully help me to develop theory around the navigation of boundaries in early intervention in psychosis services, and influence policy and training in this area.

Why have I been invited?

The study is open to all Lead Practitioners in xxxxxx Early Intervention in Psychosis Services, providing they have worked in an Early Intervention Service for over 4 months. The study has been advertised across the early intervention in psychosis services in xxxxxxx, and this information sheet is given to those who have enquired further.

Do I have to take part?

The study is entirely voluntary and it is completely your decision whether you would like to be involved. You might like to take some more time after finding out about the study to make your decision. You can change your mind about participating up until the point interview data analysis is completed (estimated January 2021), without having to give a reason.

What is involved in taking part?

If you would like to take part in the study you would be asked to participate in an interview with the researcher where you will be asked about your views, experiences and clinical practice around boundaries and how these have developed. The researcher will also ask you for some demographic information such as age, gender, ethnicity, and how long you have worked in the service. I will arrange this interview with you directly, via videoconferencing. The interview will last no longer than one hour and breaks can be taken as needed. The interviews will be audio recorded using a Dictaphone.

What are the possible disadvantages and risks of taking part?

We do not anticipate that there are any risks to taking part, however you could find some of the questions slightly personal and you can choose not to answer them. All questions are voluntary, so you do not have to answer anything you don't want to. If you do feel affected by the interview, we would encourage you to speak about this with your supervisor or line manager.

In the event that you were to disclose a serious boundary violation or serious safeguarding concerns which have not already been reported, we would have a duty to break confidentiality, and concerns would be raised in line with Sussex Partnership NHS Foundation Trust policies. You would be reminded of this after such a disclosure was made. Examples of serious boundary violation disclosures could include if a participant were to disclose a sexual relationship with a service-user, or accepting large sums of money from a service-user.

What are the possible benefits of taking part?

There are no direct benefits to you taking part in this study, however the responses you give will help to develop theory around how staff perceptions of, and clinical practice in, boundaries are developed in early intervention in psychosis services. The resulting theory could influence policy and training in this complex area.

What if there is a problem?

If you have a concern about any aspect of the study, or any possible harm you might suffer during the study, this will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice in line with General Data Protection Regulation rules and all information about you will be handled in confidence. The details are included in Part 2 on the following page.

Information Sheet: Part 2

What will happen if I don't want to carry on with the study?

You can change your mind about participating in the study at any point without having to give a reason, up until the completion of interview data analysis (estimated to be around January 2021). If you withdraw from the study, any data we have collected from you up until this point will be destroyed/deleted, and removed from analysis of the project. However, if you simply no longer wish to be contacted in relation to the study, you can withdraw your consent for this at any stage.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me or use my contact details at the end of this information sheet, and I will do my best to answer your questions.

If you remain unhappy and wish to complain formally, you can contact Dr Fergal Jones, Research Director at Salomons using the contact details below:

Dr Fergal Jones, Research Director, Salomons Institute for Applied Psychology. Email: fergal.jones@canterbury.ac.uk Telephone number: 01227 927070

You can also contact xxxxxxxxxxxx's Patient Advice and Liaison Service using the following details:

Patient Advice and Liaison Service
xxxxxxxxx
xxxxxxxxxxx
xxxxxx
xxxxxxxxxx
Tel 0300 304 2198
Email: pals@xxxxxxxxxxxxx

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential, and will be handled in line with General Data Protection Regulation and the Data Protection Act. All information or notes from the study will be anonymised, and your interview will be given a code number (rather than your name). The interview recording and transcript will also be kept confidential, and will be stored securely on an NHS password-protected encrypted memory stick. The original recording on the dictaphone will then be destroyed. Only the researcher and the two supervisors involved in the project will have access to your information. The only circumstance in which this confidentiality would be broken is if there were concerns about the risk to yourself or another person. Participants have the right to check the accuracy of data held about them and correct any errors.

After the project is completed, your consent form will be stored securely at the Salomon's Institute for Applied Psychology for approximately one year after which time it will be destroyed. A copy of your interview transcript will be retained in anonymous form by Salomons Institute for Applied Psychology for 10 years following completion of the study, after which time this will also be destroyed.

What will happen to the results of the research study?

Data from all the participants will be analysed and the results written up in the form of a Major Research Project, as this research forms part of clinical psychology training. It is also possible that the research will be published in a peer reviewed academic journal; however no identifying information will be used in the Major Research Project or any journal publication. It is possible that a quote from the interview will be used in the project write-up and journal publication, but we will ensure this is also anonymous.

Who is organising and funding the research?

Salomons Institute of Applied Psychology, part of Canterbury Christ Church University, is funding and organising this study which is being conducted as part of Alexandra Bone's Clinical Psychology Doctoral training.

Who has reviewed the study?

This study has been reviewed and approved by Salomons Ethics Panel (Salomons Institute for Applied Psychology) at Canterbury Christ Church University, and the Health Research Authority.

Should you wish to take part, you will be given a copy of this information sheet to keep for your records in addition to a copy of your signed consent form.

Requesting study results
You will be sent a summary report of the study findings. However, If you would like a copy of the full write up of the research study following its completion, please email me at: ab1281@canterbury.ac.uk and I will be happy to send you a copy.

What now, if I want to take part?

If you have decided you would like to take part in the study, please email me on the email below. I will then arrange a convenient time and location with you to set up an interview.

Researcher contact details:

Name: Alexandra Bone

Email: ab1281@canterbury.ac.uk

Mobile number: 07593640077

Version 2. 31.01.20

Appendix 8: Participant Consent Form

Version 3. 15.02.20 IRAS no: 274036

Participant identification number for this study:

Consent Form

Title of Project: A Grounded Theory study exploring how staff Understand and navigate boundaries in Early Intervention in Psychosis Services'

Name of Researcher: Alexandra Bone

Institution: Salomons Institute of Applied Psychology (part of Canterbury Christchurch University)

Please initial box:

1. I confirm that I have read and understand the information sheet dated ..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw up until the point of data analysis completion (estimated January 2021) without giving any reason, without my rights being affected. ☐
3. I understand that data collected during the study may be looked at by the lead supervisors Dr Rachel Terry and Dr Becky Whitfield, and give permission for these individuals to have access to my data. ☐
4. I agree that anonymous quotes from my interview may be used in published reports of the study findings. ☐
5. I understand that my data and participation will be kept confidential, unless a serious boundary violation is disclosed that raises safeguarding concerns. ☐
6. I agree to take part in the above study. ☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix 9: Demographic Information Form

Demographic Information form

Participant ID:

Age:

Gender:

Ethnicity:

Profession:

Years qualified:

Length of time in EIPS:

Previous settings/clinical experience:

Appendix 10: Interview Schedule

Semi-structured interview schedule

A Grounded Theory study exploring how staff understand and navigate boundaries in Early Intervention in Psychosis Services'

Intro: Introductions, reminder of the study and confidentiality information, invitation of questions and concerns before the interview starts.

Collection of demographic information: Using the guidance form, ask the participant for relevant demographic information, including age, gender, ethnicity, occupation, length of time in the service, and previous experience in mental health services.

Interview: This will be guided by the following questions, but in line with grounded theory, follow up questions can be guided flexibly around the participant's responses. The interview schedule will also be amended or developed depending on what emerges from theoretical sampling & initial data collection.

1. Can you tell me a bit about how you understand and navigate boundaries with service-users in this service? Prompts: What does the term 'professional boundaries' mean to you? (definition: . boundaries refer to the psychological, social, emotional, and physical space between the clinician and the client. A boundary may be defined as the "edge" of appropriate professional behavior, transgression of which involves the therapist stepping out of the clinical role or breaching the clinical role). When did you first start to think about boundaries? What do you think about when managing boundaries? Can you give me an example?

2. **Who do you think boundaries serve? How/why?**

-boundaries serving clinicians firstly, service-users own boundaries are considered secondary?

explore further?

3. **What are some of the challenges you have come across when navigating boundaries within this service?** (e.g. Technology and communication, impact of age of both parties, merging into 'friend' territory, romantic feelings/feelings of attraction, Assertive engagement vs respecting service-users own boundaries) Prompts: How did you manage these challenges and make decisions around the best course of action?

-How do boundaries link to/Impact on engagement?

4. **How do you manage these challenges?**

5. **Have you ever spoken explicitly with clients about boundaries?** Prompts: if Yes, what has that been like? Was it helpful or not? If no: why not? If yes: how was it helpful? Do you ever negotiate boundaries with service-users?

6. **What have you found helpful when navigating boundaries?** Prompts: In what ways is this helpful? Has this always been the case? Why do you think this is helpful? What has led you to see it as helpful? Can you give me an example/times when you have been uncertain and how it was helpful?

-What do you find helpful about the process of doing this? What do you gain/how does it help?

7. **Do you always manage boundaries in the same way**? Prompts: Do you think about/manage boundaries in the same way with every client? Are the same things important in every situation? In what situations do you think about or manage boundaries in a different way? Or when working with different staff members? Have you always done this? What has changed? How did these changes come about?

Do you ever negotiate boundaries with service-users?

8**. Are there any differences in how you manage boundaries within this service compared to other services you may have worked in previously?** Prompts: If yes, what are these differences? Why do you think they are there? If no (but worked in other services) again, why do you think there is no difference?

9. **Are there any experiences or factors that have been really important for you in terms of developing your understanding of boundaries and how best to navigate them?** Prompts: What are these experiences/factors? When/how did you notice these? Why do you think they were important for you? How have they helped you? Has anything changed in your clinical work as a result of this?

Things you always hold in mind when thinking about boundaries?

10. **Do you ever feel like you have got the boundaries wrong?** Prompts: what was the situation? What did you? How did it, or did it affect the relationship with the service-user?

11. **Have you ever had any specific training around boundaries?** Prompts: If yes, was it helpful or not? Do you think it influenced your clinical practice? If no, is this something you would want/find helpful or not?

12. **How confident do you feel in navigating boundaries effectively?** Prompts: Has this always been the case? What has changed? How has this changed over your time in mental health/EI services? What is likely to affect your level of confidence in navigating boundaries? How have you noticed this? How has this impacted in your clinical work? Do you think your colleagues feel the same way?

Additional areas developed during interviews:

Impact of covid-19 on boundaries?

What factors about the service influence your boundaries?

What is the difference between a professional relationship and a friendship? How do you draw the line between supporter and friend?

Do you have any further thoughts about boundaries that you think it would be helpful for me to know?

Appendix 11: Examples of Open Coding

Participant		Yeah
Interviewer		The kind of different environment as well, um, I guess any, any thoughts on how that might kind of impact on boundaries or, or not, or how, how boundaries are, kinda still maintain a shape within those kinds of contexts?
Participant	24:46	Yeah, yeah that's a, that's an interesting one because it, it brings in, th-other people, the general public
Interviewer		Yeah
Participant		And so then I'm kind of like, I'll have to put in two heads in almost, like I'm thinking about the therapeutic relationship with the client
Interviewer		Mhmm
Participant		And what that looks like and how that interacts. And then in the back of your mind you're like, you've got an awareness of like what does this look like to the neighbours that I'm knocking on the door, or the people that are walking in the street, or the other people in the cafe? Like
Interviewer		Mmmm
Participant		Who do they think I am? Like, does it, is it, how obvious is it that I'm a clinician working there? How much of a problem is that for the, for the client?
Interviewer		Yeah
Participant		Um, and, and some people I walk around with, um, er, and, er, they just stop talking when another person's walking past
Interviewer		Yeah
Participant	25:35	Other people are completely oblivious to it and I'm like, ahhh, I think we should, you know le-let's just, so I, I, I might, roll generally with that, as to try and like keep the conversation, you know, it's to keep it discreet, so I'm always thinking about yeah who's around at this time and who's, who's listening in on this and it doesn't matter whether they, you know, don't know anything it's just like it's, it's none of their business so, it it's sort of, keeping that there. Boundaries with parents, that's really, really complicated
Interviewer		Mhmm
Participant		Um, really, really complicated, particularly with the people who are living with their parents and, y-y-yeah, and that's, that's really really difficult because, um, and I guess that sort of goes back to a place where you do have to make decisions which are beyond the exact, direct er, request of the, of the young person particularly when they're unwell, sometimes you just, you just need the information from the parents, and you need to reassure the parents to some extent as much as you can, without disclosing confidential information that, you know, it's, it's alright or, it's

Commented [AB1]: Meeting in public places-bringing the public into/navigating the public in addition to the interpersonal relationship/boundaries
Having a public "layer" to the boundaries

Commented [AB2]: Dividing attention between the interpersonal/therapeutic relationship and public awareness

Commented [AB3]: Dividing attention between the therapeutic relationship and public awareness

Commented [AB4]: Questioning/considering the public perception/view

Commented [AB5]: Considering client preferences around public perception

Commented [AB6]: Experiencing a range of client's own "privacy boundaries"

Commented [AB7]: Clinicians protecting client's own privacy for them

Commented [AB8]: Navigating boundaries with parents-going against SU's preferred boundaries to obtain necessary information

not alright, you know, that it that t t t to kind of, be able to communicate that and that's a really really complicated one to navigate but you just have to navigate it

Commented [AB9]: Supporting parents without disclosing confidential information

Interviewer Mhmm

Participant There's no, um, er, no way. There's another good example I just wanted to

Interviewer Mmm?

Participant 26:54 Put in, sort of probably more for the first question but but um, again I saw this client yesterday, the same person but, but um, he's been *really* keen to go for a bike ride

Commented [AB10]: Listening to client's preferences

Interviewer Mhmm

Participant And that seems to be his thing. And, I brought my bike last time and we went for a bike ride and that was fine. And then, this time I couldn't, complicated reason but for some reason I couldn't bring my bike

Commented [AB11]: Engaging with him through his hobby

Interviewer Mhm

Participant 27:18 And I turned up there and then he was like "well, you could borrow my parent's bike" And I was like (laughs) errrrr, this is weird with boundaries and covid and

Commented [AB12]: Being propositioned, deciding what to do

Interviewer Mmm!

Participant Everything like that and he was so keen to go, and I just thought well actually what's the harm, he was like "my parents said you could use it". Um, you know, probably if I told somebody from a risk assessment, I hope this doesn't go to them, but, but but if I told somebody from a risk assessment like "what you used somebody else's bike and you didn't have a helmet and you didn't have a", you know all the, all the sort of things that I can say like I'm, I'm managing my own health and safety are not there, but, but I know as a person I'm confident you, riding a bike, I'm confident that I can separate, if I fell off that bike or something happened ,that I would just deal with it, as it, you know, it's a slightly, slightly odd one but, but

Commented [AB13]: Evaluating the potential harm from a common-sense perspective-sidestepping the system

Feeling fearful of repercussions "I hope this doesn't go to them"

Commented [AB14]: Experiencing tensions/inner conflict between the formality of the system and the realities of working with clients

Interviewer Yeah

Participant I know that I, I know that I could deal with it

Commented [AB15]: Believing in one's own competencies/skills-sidestepping the system

Interviewer 28:12 Mhm

Participant Whatever "worst case scenario" was in terms of risk, I would be able to manage it and deal with it without it being a calamity

Commented [AB16]: Considering "worst case scenario's", believing in one's own skillset/competencies to manage this safely

Interviewer Yeah

Participant Um, er, a-and I was weighing that up against you know, the disappointment of this person who's like, he would, he'd been texting me and calling me saying "are you gonna bring your bike, are you gonna bring your bike" and

Commented [AB17]: Weighing up potential risks vs benefit to client

Interviewer		Aww
Participant		It was obviously really, really important to him, and, er, you know, and I enjoy a bike ride as well myself. So it wasn't like, it wasn't, I thought, I just weighed up the, the harm, the potential harms and how they might be managed and the-the potential, you know, er, sort of, er, yeah, impact on him
Interviewer		Mmm
Participant	28:53	Er, and is there, and which maybe, you know, and I'll discuss it in supervision, but maybe that boundary was a little bit
Interviewer		Mmm
Participant		You know, not, not appropriate, it might be more appropriate to say "well let's do it another time you know, let's go for a walk today", um, but, yeah, anyway, so that's, so that was a really difficult, those are the sort of difficulty dilemmas you're facing like, what do you do?
Interviewer	29:14	Yeah, that sounds like
Participant		Um
Interviewer		A really tough call
Participant		Yeah, yeah
Interviewer	29:19	Um
Participant		Um
Interviewer		That does lead me nicely on actually to the other question I wanted to make sure we got in which is, what-how, what do you tend to draw on if you do find yourself in a dilemma or something you are unsure about with boundaries, what kind of resources or people do you tend to draw on to, to think through that or reflect on that?
Participant	29:41	Um, yeah, I guess supervision is a useful one. I think different types of supervision with different um team members you know, that's, that is, that is a useful one, I think, you know, speaking to the team, team leader or, um, er, yeah I guess psychology colleagues can be really good with that
Interviewer		Mhm
Participant	29:59	Um, and also yeah, as you know, as you get to know individuals, you know, you kind of can anticipate what they're gonna say depending on who it is, because it's not a clear thing
Interviewer		Mm
Participant		Like you will get five different responses to whether you should have ridden that

Commented [AB18]: Clinician not wanting to disappoint client-impacting on decision/judgement?
Clinician's own preferences feeding into the decision made (Memo: is this ok/helpful or not? "Who am I doing this for?" idea)

Commented [AB19]: weighing up potential harms vs benefit to client/impact of not doing it

Commented [AB20]: re-evaluating decisions made around boundaries

Commented [AB21]: demonstrating/conveying the dilemmas faced
not knowing the answers

Commented [AB22]: working through dilemmas-using supervision

seeking advice/opinions from different team members e.g.
-team leader
-psychology colleagues

Commented [AB23]: Recognising individual differences in stances on boundaries

Commented [AB24]: Recognising individual differences in stances on boundaries

bike

Interviewer Yeah

Participant Or, or not or like, you know, some people will be like, "well of course ride the bike like it's there, like just go for it, why are you thinking about it?" And, and other people would be like, "whoah, you shouldn't have done that. That's like, you know, we need to fill in an incident form", or something like (laughs), you know, you'll, you'll, you'll get a different range of responses depending on who that person is. And I think that's a really key thing to who this, what this job is, is like, you cannot, you, you, you it's, it's unhealthy and it's, it it's, it's unrealistic to expect that people will not be themselves to some extent in their work

Commented [AB25]: Conveying multiple stances/viewpoints around boundaries

Commented [AB26]: Conveying different approaches/views around risk, and following system protocols

Commented [AB27]: Integrating aspects of professional and personal selves-personal views/values impacting on professional self/actions

Interviewer Mmm

Participant And, as individuals who vary, like our boundaries vary depending on so many complex interactions and, and, you know, as I was saying about diversity, you know that's part of the richness of it actually, that you will get lots of different responses so

Commented [AB28]: Recognising individual differences in boundary stance
Based on complex interactions

Interviewer Yeah

Participant So, so yeah, so team, team members, um, yeah, I mean family you know, if I'm, if I'm unsure about stuff, you know they're not, not disclosing confidential information stuff, then just, you know, sometimes just talking to my partner can be really helpful about that

Commented [AB29]: Working through dilemmas-confiding in their partner

Interviewer Mhmm

Participant If I'm you know, really kind of playing over the boundary because it's sort of outside of work and it's kind of a little bit, you know sometimes when they're, they're these kind of, you know, there's, there's what you know to do in terms of keeping people safe and, and following guidelines and, and making sure that risks are met and so on, which is, that's team based stuff. But there's, sometimes there's just ethical dilemmas

Commented [AB30]: "playing over the boundary"-debating whether or not it falls outside of professional role

Commented [AB31]: Separating key/essential work "tasks" and ethical dilemmas requiring a more philosophical approach

Interviewer Yeah

Participant Um that, that are, that you're, that you're kind of curious about, it fits more philosophical than, than actually, you know, service based stuff, it's

Commented [AB32]: Separating work "tasks" and ethical dilemmas requiring a more philosophical approach

Interviewer Yeah

Participant That's sort of where it goes into, um, so, so yeah, so so, so, team members, supervisors, different, yeah people around, yeah

Interviewer Mmm, ok

Participant Um, and the clients themselves as well and their family, you know, like that's the other thing with the, with these

Commented [AB33]: Working through dilemmas-Consulting with the client themselves and their families

Interviewer		Yeah
Participant		With these dilemmas the family is often really important that you're like, I, I don't you know, they've asked me, you know sometimes you just, they've asked me not to disclose this, and I think, but it's really important that you're able to, to still communicate you know, s-s-so you so you kind of, you can be a bit guided from them, and
Interviewer		Mmm
Participant		And often, you know, nine times out of ten actually the family are really, you know they're there they're thinking about their, their young person, they want what's best for them
Interviewer		Yeah
Participant		And, if you kind of guide them that actually it's not helpful for you to know that, at the moment, then, that can be there but, but they can also guide you in terms of like "well I think it's more important that we find this out because, this" so you
Interviewer		Yeah
Participant		Yeah
Interviewer		Yeah
Participant		Yeah
Interviewer		No, really useful. I'm aware of the time. Any other
Participant		Yes
Interviewer		I guess, final thoughts or ideas that you've had on, on kind of boundaries within EIS that we haven't covered or touched upon?
Participant	33:01	Er... er, I've gone a bit blank actually, um, there are, there are a few I mean, there's things with groups I spose?
Interviewer		Mmm?
Participant		That's, that's another boundary is like introducing clients? You often like in your head you start matching up different clients
Interviewer		Yes
Participant		Not, you know, not in, you know, just, you just think like, they've got, they, why the hell do these people, they're sitting in their rooms, both of them on their own, why don't they go and hang out with each other
Interviewer		Yeah
Participant		Um and It, it's really frustrating, but then you're like, well how do you, how do you

Commented [AB34]: Working through dilemmas- consulting with families, balancing confidentiality requests with maintaining communication with family

Commented [AB35]: Conveying family have best intentions for their child

Commented [AB36]: Guiding family and being guided by family

Commented [AB37]: Thinking about the boundaries between clients

Commented [AB38]: Feeling frustrated by barriers professional boundaries can create

Participant		create that, that space where they can, they can interact	**Commented [AB1]:** Thinking outside the box/seeking creative solutions
Interviewer	33:34	Yeah	
Participant		Er, you know that's a useful clinical thing that it's, it's, you know you have to, to some extent or another, break professional boundaries by, just by introducing them as being from the same service so	**Commented [AB2]:** Avoiding "breaking" professional boundaries
Interviewer		Mmm	
Participant		You know, group, groups is the only way that we have really properly to do that at the moment	**Commented [AB3]:** Using groups to enable connection between service-users
Interviewer		Yeah	
Participant		Um, you know you invite people to groups and they come along and they make that choice themselves	**Commented [AB4]:** Enabling people to connect with others
Interviewer		Yeah	
Participant		Um, but, but there are times where you think actually, you know you, they- often those people who, who are locked away in their room playing computer games or whatever, um, wanting interaction with people, also won't go to groups so	**Commented [AB5]:** Acknowledging barriers/difficulties with accessing groups
Interviewer		Yeah	
Participant		How do you, how do you create that, um, er, that space where, you can get there so there, so there's, so there's yeah, interactions between, between clients and, and boundaries between them	**Commented [AB6]:** Thinking outside the box/seeking creative solutions **Commented [AB7]:** Thinking about the boundaries between clients
Interviewer	34:22	Yeah	
Participant		Well also you know, you know sometimes it comes up like, you know, that that two people are in a relationship and you know that, for one reason or another, there's there's serious risk concerns about, because you have information about one or other of the clients	**Commented [AB8]:** Working through ethical dilemmas-invading personal privacy due to safeguarding concerns/duty of care
Interviewer		Mhmm	
Participant		And you're worried about the vulnerability of the other, er, how do you, yeah, that's another kind of complicated one with, with boundaries.	**Commented [AB9]:** Working through ethical dilemmas-invading personal privacy due to safeguarding concerns/duty of care
Interviewer	34:43	Yeah, really interesting, yeah, that hasn't actually come up so far in my interviews so thank you yeah, that's really er	
Participant		Yeah	
Interviewer		A good one to think about, um	

Appendix 12 Selective and Theoretical Coding

NB: Due to the hundreds of codes produced, the list below contains examples from each category rather than the full catalogue.

Category	Sub-category	Codes
Individual LP Boundary Decisions	Employing Flexibility	Being flexible depending on the situation Starting very boundaried (young person), Becoming more flexible Adapting your boundaries and way of working depending on the service. Facilitating flexibility for clients (e.g around hours). Flexing depending on circumstances/context Facilitating client choice/Honouring client preferences in communication means/Being flexible/adapting communication method to suit the client. Fitting in around their lives. Considering how flexing the boundaries (e.g., accepting a gift) will impact the relationship/clinical work. Stark contrast of individual, personable approach and wider service/operating constraints serving as quite a stark/ harsh reminder for clients that clinicians are part of a bigger service/system.
	Making decisions on an individual basis	Designing the relationship on an individualised basis Knowing when to retreat/withdraw Managing difficult requests from clients Deciding what/how much to self-disclose on an individual/case by case basis (without crossing the "red lines"-for most participants), decision informed by contextual factors (e.g., client history of engaging, risk, their ways of managing interpersonal relationships) Deciding where to draw the line (links to fearing oversharing/self-disclosure spiralling out of control?) (-e.g., fish and chips).
	Using instinct & clinical judgement	Gauging, assessing client before deciding how to implement boundaries Drawing on/listening to instinct/gut feeling Listening to feelings of discomfort. Holding/containing therapeutic space for the client. Assessing risk. Experiencing emotional burden/exhaustion of micromanaging/monitoring your behaviour 24/7. Evaluating/reflecting on own feelings/instinct around a boundary.
	Considering motive/rationale	Reflecting on motive (clinician anxiety, ending up in Coroner's Court). Transference? - bringing our own "stuff", experiences into clinical practice. Providing "therapeutic space" Noticing one's own motives for wanting to meet with clients Noticing whose interest/benefits it is in Acknowledging and resisting a desire to always be actively "doing something" with clients. Noticing maternal instincts/tending towards a maternal relationship. Self-disclosing to provide a different perspective.
	Incorporating moral/ethical values	Being guided by your own morals and beliefs Balancing official "rules"/codes of conduct with integrating own moral/ethical principles/core values. Calibrating moral/ethical compass. Integrating aspects of professional and personal selves-personal views/values impacting on professional self/actions.

	Drawing personal boundaries	Drawing internal/personal boundaries for yourself (most participants)/boundary within the boundary. Choosing which parts of identity to share -sharing enough to convey shared/common experience -protecting private/personal details/life. Providing vague information in relation to "red line/red tape" topics. CONTRAST- also Differentiating between professional and personal domains, implementing a boundary division -avoiding "leakage". Drawing "red lines" participants never cross, fixed things /drawing personal boundaries. Differentiating between personal boundaries (participants drawing their red lines) and professional boundaries (red lines that are drawn for them). At boundaried end-self-disclosing in a way which is relevant and minimal. Responding to "red tape" topics/self-disclosure requests in vague terms. Avoiding rejecting client; finding a middle ground without compromising own personal boundary.
Team	Consulting colleagues	Trusting colleagues - Implicit assumption: Their approach is the "right" way to approach? Feeling able to share emotions/vulnerabilities with colleagues. (Service model/colleague interactions mirroring client interactions?) Thinking about situations from the client's perspective (using peer workers). Seeking others' opinions to inform decision-making and future actions. Sharing with the MDT. Expecting/welcoming colleagues' feedback/constructive criticism. keeping in check own clinical judgement faculties.
	Holding Complexity	Containment - (making it easier/more containing for clinicians-avoiding holding all the complexity and conflict within themselves, instead locating this conflict within opposing clinicians? Sharing burden/complexity within the team, - supporting each other. Sharing cognitive/emotional burden and decision-making within the team. Involving other colleagues in the work (with the client-directly or indirectly) - to ensure feeling safe/preventing further boundary breaches.
	Shared decision making	Shared problem-solving, shared decision-making. Involving other colleagues in the work (with the client-directly or indirectly) - to ensure feeling safe/preventing further boundary breaches. Using team discussion for less clear-cut, more nuanced boundary issues. Sharing cognitive/emotional burden and decision-making within the team - "tapping into the greater mind"/using the "team brain. Sharing risk within the team.
EIS Model	Creativity	Creativity enabling engagement. Relaxing boundaries fostering creativity. Thinking outside the box/being creative. Creativity whilst maintaining professionalism; balancing creativity and professionalism. Benefits - enabling creativity, closer, more meaningful relationships, **but** costs more - emphasis on clinicians own decision-making process means a more stressful process- constantly assessing, evaluating, adapting, second guessing decisions made-exhausting process.
	Authentic Relating	Service context of EIS-culture/ethos-standing alongside/authentic relating/reducing power imbalance.

		Genuineness /-authenticity /-making clients feel comfortable Engaging/building rapport through a common interest. Embracing and using common interests with clients. Having shared experiences with clients/Relating to client's experiences. Witnessing personal growth and supporting clients to turn their lives around Placing importance on the quality of the interpersonal relationship first and foremost. Conveying authenticity/genuineness/humanness (also avoiding being idealised/positioned as rescuer by client).
	Using self-disclosure judiciously	Relating self-disclosure to improving client engagement. Avoiding an "easier ride" -considering clients' needs rather than clinician desires/needs. Relating hiding behind boundaries to self-disclosure. Secret shared experiences- (possibly linking to questions around knowledge/information-who gets access to what information about whom/ who gets to share what information?) Holding back from/resisting sharing common personal experiences. Implicit assumption: yearning to share, to demonstrate understanding. Prioritising client's experiences of their distress over sharing own experiences (and communicating understanding, shared experience). Not self-disclosing so as not to undermine client's experience Prioritising client's own experience of their distress; validating client's experience instead of self-disclosing own Maintaining focus on client as opposed to clinician/ensuring client remains focus. Knowing motive/reason for self-disclosing Self-disclosing to provide a different perspective. Asking permission to share, avoiding making assumptions.
	Building/forging close relationships	Closely linking/associating boundaries with engagement/relationship building. Noticing maternal instincts/tending towards a maternal relationship. Importance of holding your boundaries in mind (mitigating risk of merging into friend territory) Building relationships whilst maintaining boundaries. Forming alliances with certain clients Engaging/building rapport through a common interest. Embracing and using common interests with clients Having shared experiences with clients/Relating to client's experiences. Bending boundaries to accommodate/develop a rapport/therapeutic relationship. Ensuring trust Understanding the difference between having rapport and providing professional help, and friendship. Experience of ruptures in the relationship -repairing and rebuilding the relationship Fostering closeness -inviting/risking blurring of personal/professional divide. Forming longer term relationships within EIS -rendering boundary setting more complex.
	Standing alongside clients	Service context of EIS-culture/ethos-standing alongside/authentic relating/reducing power imbalance. Standing alongside clients (most participants) (and alongside family members. Standing alongside clients during their life journey. Getting/standing alongside clients -being with them (as opposed to? In opposition to them? Operating solely in a position of power?)

		Setting boundaries explicitly feeling at odds/in conflict with standing alongside clients.
	Power relations	Being aware of power dynamics-a clinician and an older white man-Linking into wider societal narratives around race, gender, age, authority Clinicians being aware of their own social GRAAACCESS interacting with client's GRAACCCESS Professional role involving a monetary element - implying power/professional responsibilities/rules/the kind of conversation/relationship you can have. Realising power inherent within role. Respecting role and privilege Minimising power dynamic/levelling power/creating a flattened hierarchy of power within EIS Balancing out the relationship/redistributing power in the relationship
	Meeting outside the clinic room	Meeting service-users in settings outside the traditional clinic room. Normalising effect, - working outside of the medical model? reducing sense of professional/patient roles Facilitating/fostering better relationship building But - Dividing attention between the interpersonal/therapeutic relationship and public awareness. BUT tacit assumption: within some/certain confines (e.g., meeting could not take place at practitioner's own house)
	Family stuff	Justifying engagement work to family managing their expectations (expecting the medical model) Becoming too involved with family members -consent being withdrawn-overstepping client's personal boundaries Standing alongside family members and clients Conveying professional expertise to parents Reassuring families Enabling/wanting parents to take you seriously Getting families on board/on side Working with families-different clinicians working with different family members: working in a way that feels safe for professionals but is fragmenting for the family? ((clinicians set up mirroring what is happening within the family?) Containment needs of the professional versus realistic experience for/needs of the family
Support		Framing help/support in a helpful/non-threatening way Supporting clinicians. "Fitting in" to client's lives in the least obtrusive way. Clinicians positioning themselves as supporting/helping clients (some participants) Witnessing personal growth and supporting clients to turn their lives around. Smaller, cosier/well insulated teams. Enabling stronger connections to form within the team. Experiencing EIS as a safe working environment -also fits with different ways of working within EIS.
Transparency		Aiming for transparency within the relationship-Acknowledging inequality/imbalance of relationship, acknowledging the purpose of the relationship. Emphasising importance of openness, transparency. EIS culture guarding against boundary violations (due to open, transparent culture, shared discussion. Being open and transparent with the team

Professional bodies/organisational policy level	Code of conducts (rigid level)	Being guided by the code of conduct. Drawing upon understanding of codes of conduct. Presence of boundaries meaning client disclosing- knowing and trusting clinician to take charge/responsibility for the situation -client needing clinician to be in/take position of power/authority. Being mindful of clinician as an agent of social control/instrument of authority. Service/team/clinicians prioritising their own agenda over client's - Misaligned needs - (too fearing of safeguarding/risk implications of not intervening/intruding?) Boundaries preventing/ protecting against immoral/unethical practice/behaviour from both/all parties. -protecting clinicians from allegations. - protecting clients from unethical practices, allegations. Boundaries serving to protect against transgressions in both directions in the relationship Boundaries serving both client and professional (T10) Boundaries serving/propping up/reinforcing the organizational structure Rebelling against/ignoring imposed organisational rules/policies.
	Professional / personal boundary divide e.g.: professional obligations	Balancing official "rules"/codes of conduct with integrating own moral/ethical principles/core values Integrating aspects of professional and personal selves-personal views/values impacting on professional self/actions More personal contribution/bringing of personal self (vs professional self) to the relationship Wrestling with expectations from the nursing profession/governing bodies. Feeling forced to conform to professional expectations in personal life Changing behaviour within personal life to reflect professional role… OR Interactional relationship between professional role and personal life. Carefully crafting/monitoring portrayal of self on social media - fearing repercussions. Fighting natural instincts/subduing natural instincts in favour of following imposed organisational rules. Boundaries ultimately serving/preserving professional identity. Boundaries supporting clinicians to uphold/maintain professional standards, regardless of personal feelings
	Avoiding threat to self	Reflecting on motive (clinician anxiety, ending up in Coroner's court. Nursing training emphasising potential risks/harms (allegations, coroner's court). Risk of "falling into" more relaxed boundaries-implies it is not a choice/conscious decision, but an unconscious process Fearing boundaries spiralling out of control. Hearing/reading about/witnessing/dealing with boundary violations- e.g., NMC hearings or "horror stories" or cautionary tales (when told by more senior colleagues) -sticking power of these stories- Reinforcing/alerting to seriousness of boundaries Serving clinicians personal safety and working practices.
Struggling with balance		Balancing building rapport/relationships and maintaining boundaries Clients struggling to adapt to new boundary implementations. Sense of Pulling/pushing dynamic (Pulling/hooking clients in, then pushing them away? To avoid overreliance/dependency) Sense of EIS model encroaching on client's boundaries/personal lives- disrespecting their boundaries. Acknowledging/reflecting on double standards:

		Professionals' personal boundaries respected/enforced over client's personal boundaries Balancing assertive engagement vs respecting service-users privacy/personal boundaries-not intruding/invading. Is it invading privacy or caring/undertaking welfare checks? Walking the line between assertiveness and harassment/intruding. Intervening in client's lives -crossing boundaries/walking the line between involvement in client's lives and intrusion. Professional duty of care/safeguarding responsibility overriding service-users' personal privacy/boundaries, maintaining an ethical stance **Or** Balancing Professional duty of care with service-users' personal privacy/boundaries-blurring their preferred boundaries/with their own choice/agency/capacity? Wrestling with conflict/tension between allowing person choice and agency (living their life how they wish to), respecting their wishes, vs keeping them safe/duty of care. OR… walking the line between client choice/capacity/agency and duty of care
Navigating Assertive engagement		Balancing engagement work with maintaining boundaries Enmeshed nature of boundaries and engagement within EIS Focusing on engagement as primary task (most participants). Working with people who do not want to be working with you (most participants) Difficulties of disentangling boundaries and engagement Enmeshed nature of boundaries and engagement within EIS Undertaking engagement work around client's own goals). Clients implicitly understanding the nature/purpose of the relationship Providing "therapeutic space" perceiving this as a nuanced process Sense of EIS model encroaching on client's boundaries/personal lives-disrespecting their boundaries. Personal approach leading to clients feeling hurt/rejected by clinicians when boundaries are then enforced. Becoming too involved with family members -consent being withdrawn-overstepping client's personal boundaries. Balancing assertive engagement with allowing/facilitating client choice/preference/agency (in how they live their life). Considering/reflecting on the motive and impact of assertive outreach. Motivating and enabling v harassing? Disabling? Asserting the boundaries of their role as a practitioner-Impacting the interpersonal relationship/engagement. Acting beyond assertive engagement or withdrawing: Realising intrusion/invasion of client's own personal boundaries. Reframing boundaries (e.g., receipt of gifts)-distancing, making less personal (e.g., "they are for the team"
Individual boundary decisions influenced by:	Innate/natural stance around boundaries (e.g.: a spectrum)	Initial starting points/natural stance/ "innate" stance. General attitudes (beginning stance around boundaries)- Having or employing "general rules" around boundaries-a general individual stance. having a general stance or starting point which is looser or stricter in relation to boundaries Adopting a staunch/rigid position. Positioning self along a boundary spectrum Positioning self and colleagues along a boundary spectrum. "Trusting" they approach issues in a similar way.

		Position/stance you take on boundaries being reinforced by others in the team Earning a reputation (making it more difficult to change practice?).
	Training experiences	Professional training course and/or previous jobs (e.g., forensic inpatient, prison, wards, personality disorder services). Service/placement settings/background shaping your boundary practice -carrying stances/practice with them through their career. The importance of early training experiences in shaping thinking around boundaries- e.g., focusing on personal safety always in the back of your mind. Using a live space more useful than very structured/specific training.
	Shaping moments (individual learning / growth?)	Standout factors/experiences which shape understanding/practice around boundaries. Previous experiences shaping knowledge and practice around boundaries. General attitudes (beginning stance around boundaries) - impacted by training experiences, major key events "shaping moments". Service/placement settings/background shaping your boundary practice. (Also fits with individual stance towards boundaries) Previous experiences heightening awareness of boundaries. Learning/absorbing from managers/more experienced colleagues. Witnessing fallout of boundary violation. Hearing/reading about/witnessing/dealing with boundary violations- e.g., NMC hearings or "horror stories" or cautionary tales (when told by more senior colleagues) -sticking power of these stories- Reinforcing/alerting to seriousness of boundaries. Reading in textbooks-e.g., "judicious use of self-disclosure as a tool for engagement".
Learning calibration cycle	Gaining clinical experience & tacit knowledge	"Playing it safe" with boundaries during training/shortly after training. Boundaries evolving - both within relationships with clients and within clinician's careers (similarity-some evolving, others remaining similar. Boundaries as an in-vivo experience-Something you cannot teach, but learn on the job Recognising sphere of competency as a boundary within itself. Having a greater understanding/confidence of weighing up risks vs benefits of pushing boundaries. Recognising grey areas with experience, feeling more comfortable working within the grey area.
	Constant comparative process / "calibrating"	Positioning self and colleagues along a boundary spectrum Position/stance you take on boundaries being reinforced by others in the team - earning a reputation (making it more difficult to change practice?). Boundaries serving as a benchmark, method of comparison for clinicians Comparing your practice to other clinicians- Questioning own practice; comparing self to others; yearning to know more about others' practice Considering it best practice to check out decision-making/clinical judgement with others Learning about self as a practitioner and drawing/developing own boundaries- "red tape" process in action.
	Reflecting on practice	Questioning/reflecting on own position around boundaries (some participants) Reflecting on what is being neglected/forfeited by taking a stricter stance (e.g., professional curiosity). In-vivo learning experiences with clients -provoking/prompting deeper exploration/reflection around boundaries. Perceiving benefits of a reflective practice group.

	Learning from others	Noticing a similar approach/outlook. (T2) Realised through MDT discussions, hearing about other practitioners' work/practice. Receiving warnings/advice around boundaries from qualified or more experienced staff. Observing/experiencing good role modelling from other clinicians. Learning/absorbing from managers/more experienced colleagues. Learning from more experienced colleagues. Consulting peer workers, psychologists
	Using supervision (?)	Using supervision, support from peers. Discussing in peer supervision groups. Experiencing supervision as more meaningful and purposeful Advocating for more emphasis on boundaries -within training, check-ins, supervision. Still seeing supervision as a tick box exercise Those supervising: Initiating supportive conversations around fears/motive. Observing clinicians taking on too much personal responsibility - leading to "arousal of omnipotence"? Encouraging colleagues to think about underlying processes, impact on client and self.
Timeline	Process of navigating boundaries over three years	Viewing the relationship along a timeline (within 3-year window in some cases)- doing different "tasks" at different points in the relationship. Gauging, assessing client before deciding how to implement boundaries. Boundaries implicated/implied within process of introducing self, role and service/service values. More implicitly introducing boundaries at the start of the relationship. One participant-Feeling unsure about setting "professional boundaries" with clients at the beginning- implicit assumption present for lots of participants: That setting boundaries at the beginning implies stricter, more rigid boundaries. Focusing on engagement as primary task (most participants- Focusing intensely/investing heavily in engagement work at beginning of relationship (relates to viewing relationship along a timeline-doing different things at different points in the relationship) Establishing rapport as a priority Long-term nature of 3-year service requiring flexibility/softening of boundaries. Starting with tighter boundaries? Designing and redesigning the relationship as the relationship/work progresses Boundaries evolving - within relationships with clients - genuineness /-authenticity /-making clients feel comfortable - leading to implementing boundaries retrospectively/salvaging the boundary (can pose difficulties). Difficulties of implementing boundaries at a later stage in the relationship Sense of Pulling/pushing dynamic -Point/stage in the relationship factor within the model. Clients experiencing this boundary change as odd/not being sure how to respond/adapt. Relationship disintegrating (formulated as self-sabotaging in case of one client).

Extracts from theoretical coding stage

Self-Disclosure

- Relating self-disclosure to improving client engagement (T4, T6)-could also fit with self-disclosure (p4)
- Contradiction: T5 (within their own interview, and with other P's)-apprehension in self-disclosing purely for the purposes of making it easier to engage, self-disclosing for purpose of allowing clinician an "easier ride" (p4)
- Opposition in a way - other clinicians self-disclosing to find common ground/shared interests, build rapport (T4, T9 and T10 do both) BUT above point also relates to-this is your therapy space not mine
- Links to inviting authentic relating, building close relationships, employing flexibility, transparency

Evolving Boundaries - boundaries changing/evolving with clients:

- Similarities: Starting with boundaries implicit and loose to aid/enable engagement (most participants), then tightening up later (but also questions about whether or not this is the best way from one or 2 participants, wondering whether they should have put more explicit boundaries in earlier)/focusing on engagement as the primary task. Introducing boundaries into the relationship later
- "w- that quite often happens is you, you, focus on the engagement first and the boundaries second"
- Differences-2 participants started tighter then loosens later (T1, T2)
- Contradictions from several participants-how they say they do things or how they say they would/should go about boundaries with clients changing over the course of the interview-as they reflect more on their practice throughout the interview? (e.g., T7-says tends to start with boundaries looser to facilitate engagement, then later when reflecting on an interaction with a client when they first joined, said NOW they would do things differently by starting tighter, then loosening later)-could also be due to individual client differences?

- Preparing clients for discharge/transition to other services (T6)
- -de-transitioning/easing out of the EIS model
- Critique from participants-some EIS services attending/investing more in engagement as the primary task
- -attending/investing less in endings and de-transitioning process (T9)
- doing different things in the relationship at different times
- -getting to know clients at their pace
- -e.g., engaging at beginning. End-"detransitioning"/easing out of EIS

- -working out what point they are at within the relationship
- Defining/outlining the relationship/terms of the relationship with clients (T1, T4, T13) (could also fit with processes around boundaries)

- Links to assertive engagement, employing flexibility, making decisions on a case-by-case basis

Uniqueness of EIPS:

- "And then from my first kind of shift on an early intervention placement being really like, surprised just the boundaries wasn't I guess a dirty word anymore" (T6)
- Implicit assumption: previously viewing/perceiving boundaries in a negative light-something to be wary of/viewed as a criticism/failing of healthcare professional?

- EIS culture guarding against boundary violations (due to open, transparent culture, shared discussion
- Finding it incredulous/difficult to imagine a significant boundary breach within EIS/EIS culture (T6)
- Empowering clients, fostering/nurturing independence
- Links to employing flexibility, transparency

Flexibility/meeting outside the clinic room

- Impact of setting/environment on power dynamic, who sets the rules? (T9, T10)
- -e.g., pub vs clinic room
- -is it still the clinician's decision/authority?
- Altering the power balance in the relationship/levelling of power
- e.g., context of being in an appointment/meeting with a client vs informally being with a client, e.g., on a car journey-informal interactions with clients (T3, T13)
- formal boundaries dissolving, opening up/allowing for different, freer conversations
- -lifting of "usual" formalities/boundaries
- -opening up/allowing for freer conversations
- -easing pressure
- Links to-levelling power, assertive engagement, employing flexibility.

Navigating assertive engagement:

- Balancing assertive engagement with allowing/facilitating client choice/preference/agency (in how they live their life)
- Considering/reflecting on the motive and impact of assertive outreach (T7, T9, T11, T12, T13)
- -motivating and enabling?
- -harassing? Disabling?
- Professional duty of care/safeguarding responsibility overriding service-users' personal privacy/boundaries, maintaining an ethical stance (T5, T6, T7, T11)
- Or Balancing Professional duty of care with service-users' personal privacy/boundaries-blurring their preferred boundaries/with their own choice/agency/capacity
- Links to employing flexibility, power relations, meeting outside the clinic room, navigating boundaries over time

Building close relationships

- Preferring to work with clients on a long-term basis (3 or 4 participants inc. T9)
- -enabling building of the therapeutic relationship
- -fostering closeness
- -inviting/risking blurring of personal/professional divide
- Boundaries shifting with context
- -e.g., portraying different sides of yourself in different contexts e.g., groups
- "we've had like you know groups you know, because they get to see you in a different light, you know, you're, you're engaging in that activity (Mmm) With them (Mhmm) And they don't see that side of you" (T3)
- Boundaries shifting with context
- -working together towards a goal within a group context
- -dissolving patient/professional roles
- -revealing vulnerabilities/weaknesses
- Links to authentic relating, meeting outside the clinic room, levelling power

Resisting friendship-links to building close relationships?

-boundary dilemma:

Difference-whether or not participants consider themselves a "professional friend" or not. (**Similarity-**most do not consider them to be in a friend role at all, a few view themselves as a professional friend-T7, T8 at times views the relationship as "both and" we are client and professional AND we are good friends, at other times views difference between friendship and professional role

Comparison-viewing the relationship as "both and" we are client and professional AND we are good friends-(similarities/differences between participants: along a spectrum-complete separation at one end, professional friend in middle, professional AND friend at other end of spectrum)

Distinguishing between friend role and professional role-most participants e.g., not sharing your own experiences and advice giving in the way a friend does, (assuming you know the right course of action for them),

Developing practice around boundaries

Assessing boundaries on a case-by-case basis. Gaining clinical experience to do this. Links to learning cycle?

Shaping moments (standout factors/experiences which shape understanding/practice around boundaries)

Service/placement settings/background shaping your boundary practice (most participants-also fits with individual stance towards boundaries)

Boundaries around working mirroring boundaries with clients?

Understanding why boundaries are important-theoretical stance?

Understanding boundaries

-a frame within which client interactions take place

Links between concepts-potential layers in a model?

How individuals navigate boundaries-assessing on a case-by-case basis. (all participants). A middle circle in a model? This is influenced by?:

Having an Individual relationship to/stance on boundaries/adopting a natural stance towards boundaries- (most participants)

(Like a background contextual factor in model? Or spoke at centre?)

(Find best gerunds/code to pin this down)

(Impacted by training experiences, major key events "shaping moments") BUT these influences aren't necessarily from EIS-e.g., they could have been prior influences. So do they still fit within the model?

<u>Different layers influencing participants' practice around boundaries:</u>

Thickness of layers is very different

Service context of EIS-culture/ethos-standing alongside/authentic relating/reducing power imbalance

-on interface with experienced with individual clients

Experiences with individual clients

Individual decision making-very fat layer for most

Disclosure/boundary decision at centre of this circle

(draining/cognitively challenging, team capacity influences thickness or thinness)

Training experiences-outer layer

Collapse the categories

Group into natural groups

Looking into

What factors about the service influence your boundaries?

<u>Working with clients at multiple levels:</u>

surface level interaction:

-underlying purpose/task (e.g., building relationship/rapport/trust etc.)

Factoring in client history/pattern of engaging

-e.g., easy engager- approaching the relationship differently

Placing less emphasis on engagement work.

Preserving engagement

Making boundary decisions on multiple levels, e.g., "higher level"-rule-drive, code of conduct, drawing personal boundaries for self, and day-to-day level-flexibility around boundary decisions.

TRY OUT LAYER IDEA IN AN INTEGRATIVE MAP- (including connections between categories)

-Dilemma between processes and content-focusing on processes BUT including some content, and there is other content which doesn't fit with processes but otherwise will be lost?

Appendix 13: Examples of Memos

General Interesting topics/links that have come up to explore further across interviews:

Boundaries of service-users meeting other service-users (Boundaries of service-users finding out they are being treated differently from one another)

Professional boundaries-e.g., of being a nurse. links to professional/personal boundary divide? Are the boundaries ever not there? i.e. with nursing especially-are you ever not a nurse?

Navigating boundaries changing/evolving over time: Moving on-discharge, preparing clients for different boundaries in different services-tightening boundaries at end, but looser boundaries at beginning? Is this true for all participants?

Who do boundaries serve? both, but some admittance that clinicians' boundaries are perhaps privilege over the service-users boundaries? (e.g., r.e. disclosing personal information) Links to client's personal boundaries?

also r.e. assessing risk, safety, duty of care, although also legal bounds with that

other staff members boundaries being different/inappropriate-joint working, running groups together, managing that.

intersectionality of participants' identities and impact on drawing personal boundaries/building rapport-e.g., gender, age, ethnicity. Links to drawing personal boundaries?

Interview 1 memos:

Participant 1 was not talking about boundaries in the way I expected/understood boundaries. Talking in terms of time management, managing time, not getting into jobs not within remit. This made me question my own assumptions/understandings around boundaries, and I realised these may not be shared. Later I realised he has a different take/angle on boundaries compared to all my other participants (more about time management, what is and is not your job role/responsibility). This raised questions around my assumptions/understanding of boundaries (understanding this through a psychology lens?)

-had some interesting themes, but these were not echoed in other interviews. Could still be used for contrast in some cases

Memo: being open and transparent with the team, discussing potential actions. Devil's advocate: providing the team with the option/opportunity to talk you out of it in some cases?? -Came to this interpretation via the concept/idea that the most creative/useful pieces of work you do with a client are the bits you would never tell your supervisor about!)-BUT this approach is even more so not in keeping with the EI model

Interview 3 memos

-it felt clear their family interventions training had provided them with food for thought and reflection around interesting issues which related to boundaries. Links to idea of training/prior experiences shaping participants thoughts around boundaries?

interview 6 memos:

Parts of the interview made me question whose interests are being put first? Clinician's or clients? E.g., "we ended up going for a run together because that's what I was really interested in and that's

what she was really interested in"-felt this has been a possible theme in several interviews. Could link to theme around client's personal boundaries?

Primary task as engagement, but I felt an underlying sense of a pulling/pushing dynamic

(Pulling/hooking clients in to receive treatment, then pushing them away? To avoid overreliance/dependency)

Memo r.e. Interviewer biases: assuming sexuality, assuming/revealing own tendency towards self-disclosure

topics I am drawn to/want to know more about:

Resenting/resisting the Intertwining of personal and professional identities

Professional identity overring/threatening to override personal identity

-restricting freedoms

-intruding on right to "be" personal/private self?

-feeling pressure of professional identity/duty 24/7

-feeling pressure of never-ending professional obligation overriding personal state

Wrestling with personal state/emotions/capacity vs professional obligation

-fearing repercussions/losing livelihood

Professional identity/controlling/influencing everyday decisions

Deciding whether or not to ask questions about this in further interviews-is it in keeping with research question enough? It seems reflective of the mirroring pattern observed-e.g. how participants navigate boundaries with individual clients mirroring how they operate/discuss dilemmas as a team, and mirroring service level boundaries/eligibility criteria-(flexibility)

<u>Interview 7 memos:</u>

I noticed contradictions from participant at time over the course of the interview-e.g. in how they say they do things or how they say they would/should go about boundaries with clients. This changing over the course of the interview as they reflect more? e.g. T7-says tends to start with boundaries looser to facilitate engagement, then later when reflecting on an interaction with a client when they first joined, said NOW they would do things differently by starting tighter, then loosening later. Could also be due to individual client differences? Does this relate to the EIPS timeline?

<u>Interview 8 memos:</u>

Separating roles of friendship and professional relationship-noticing contradictions within the interview-aspiring to this but not quite achieving it/harder to achieve in practice? E.g, talks about importance of not merging these roles, but then knows clients view her as a friend, and colludes with this? I am a friend AND a professional"? Fears of rejecting client/negative impact or repercussions on mental state. Links to building close relationships.

Difference-this participant avoiding explicitly addressing boundaries even when warning signs are present-fearing rejecting client? Responding implicitly instead-still communicating without risking outrightly rejecting client (T8-responding to "love you" comment)-OR threshold for when they will explicitly address boundary issues is different to others (later in the interview gave an example of when they would do this). Links to spectrum of boundaries?

Distinguishing between professional role and friend role (contradiction-before describing relationship and professional and friend relationship?). Find out more about this distinction?

Noticing lots of contradictions within the interview-representing what she knows is the "correct" answer, and how she actually feels about the relationships?

Interview 10 Memos**:**

Comparison-the way this participant is talking about self-disclosure-feels from the position of difficult situations that need deflecting/getting out of. There is less emphasis on the advantages or reasons for using self-disclosure. Differences compared to lots of other participants, similar to one or two others-suggests where they might be positioned along the boundary spectrum? And emphasis on a professional/governing level?

This participant uses more formulaic-stock answers to personal questions (self-disclosure requests), more of a standardised process (rather than more dynamic, less tailored to the individual to an extent). stock answers" as a safety blanket/coping mechanism to ensure feeling comfortable; in control? How does this link then to authentic relating theme?

Interview 11 memos:

This participant felt very open and reflective around the topic-gave me the impression this is something he has thought about and reflected on a lot before.

One part of the interview made me think about how clinicians' own interests are used-e.g., went for the bike ride, clinician ALSO enjoys bike rides. felt this has been a possible theme in several interviews. Links to ideas around whose needs/agendas are prioritised? Client's or clinicians? Or is this too cynical-actually just an enjoyable way of bonding for both parties?

Interview 12 memos:

similarity to several participants-starting from a fixed, "official" position on boundaries, then opening up/becoming more flexible as the interview goes on, and grey areas are worked into.

e.g., towards the start, focusing on code of conduct as guide for boundaries, then gradually acknowledging/introducing other elements into the decision making. Equally, at the beginning spoke about "breaking" their boundaries, sense of black and white "breaking" of boundaries. By the end of the interview, this perception had shifted/become more nuanced, to "denting" boundaries. More reflective of how boundaries are actually navigated? Employing flexibility.

This participant (as with lots of the participants) felt very open and transparent within interview process around errors/mistakes they had made or dilemmas they had faced. Sense of this mirroring openness and transparency culture within the team?

Interview 13 memos:

I noticed the same similarity again - starting from a fixed, quite absolutist position e.g., around boundaries and self-disclosure, and this relaxing or becoming more flexible as the interview goes on, and the grey areas are worked into. Links to employing flexibility?

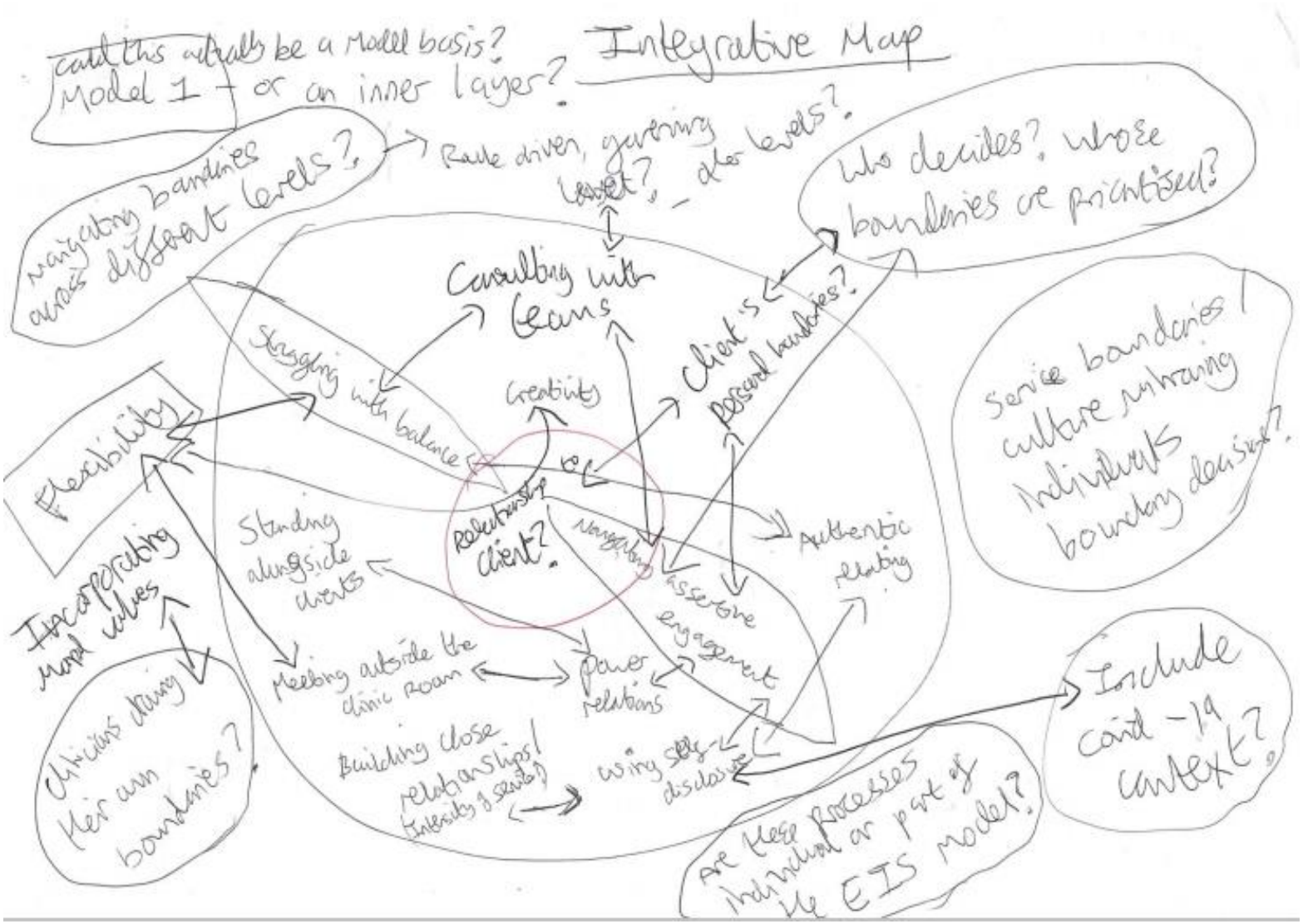
I noticed it felt like this participant was often speaking from quite a senior position or perspective, for example advising what people should be doing, and taking almost more of a managerial perspective at times. This is reflective of the roles he has done (e.g., leading boundary investigations), and his experience and banding. I wondered whether this participant's senior position was also reflected in how he talked about and viewed boundaries. For example, he often referred to following the code of conduct, or trust protocols. This is a contrast from most other participants (although I noticed another very experienced participant did this too), and made me

reflect on whether they felt obligated to include or think about boundaries in terms of official “rules and regulations” more so because of their more senior status-need to be seen to be thinking about/following these?

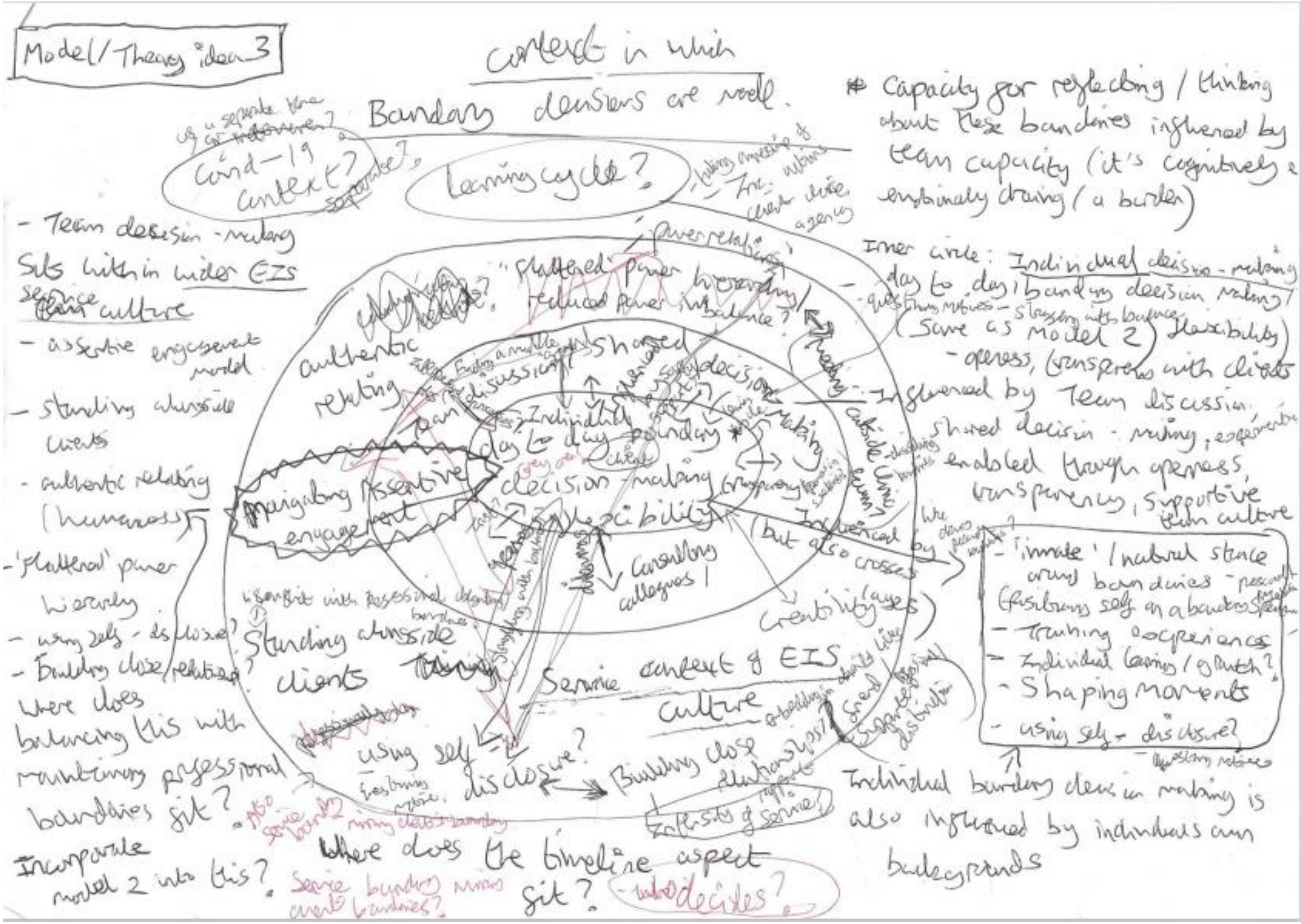
If I had been able to recruit more participants, would have been good to get more in senior/management type roles to consider their perspective.

Participant 13 had just returned to EIS after having been on a secondment in the generic CMHT. This provided a useful angle/perspective in comparison to my other participants. I noticed they were in a position to take a wider, almost outsider perspective look at the EIS model. They had noticed a sense of elitism which could sometimes be present within EIS services (a sense of “our model is the only way/best way to do things”) which is something I had picked up on in several of my other interviews too. Having just been on secondment in a pressured and struggling CMHT, they were firstly able to be more empathetic to the pressures and strains being faced by the CMHT, and secondly were in a position to refute some of the common misconceptions about other services which seemed to be present amongst EIS staff (e.g., EIS are the only community service that really texts clients, gives clients their work mobile numbers rather than making them ring duty, etc.). Whilst this may have been the case in the past, this participant was able to acknowledge the changes in practices that have been happening in the past few years, and the innovative ways they too have been practising and communicating with clients. SO, is EIPS as unique as we think in terms of navigating boundaries?

Appendix 14: Example of Integrative Map

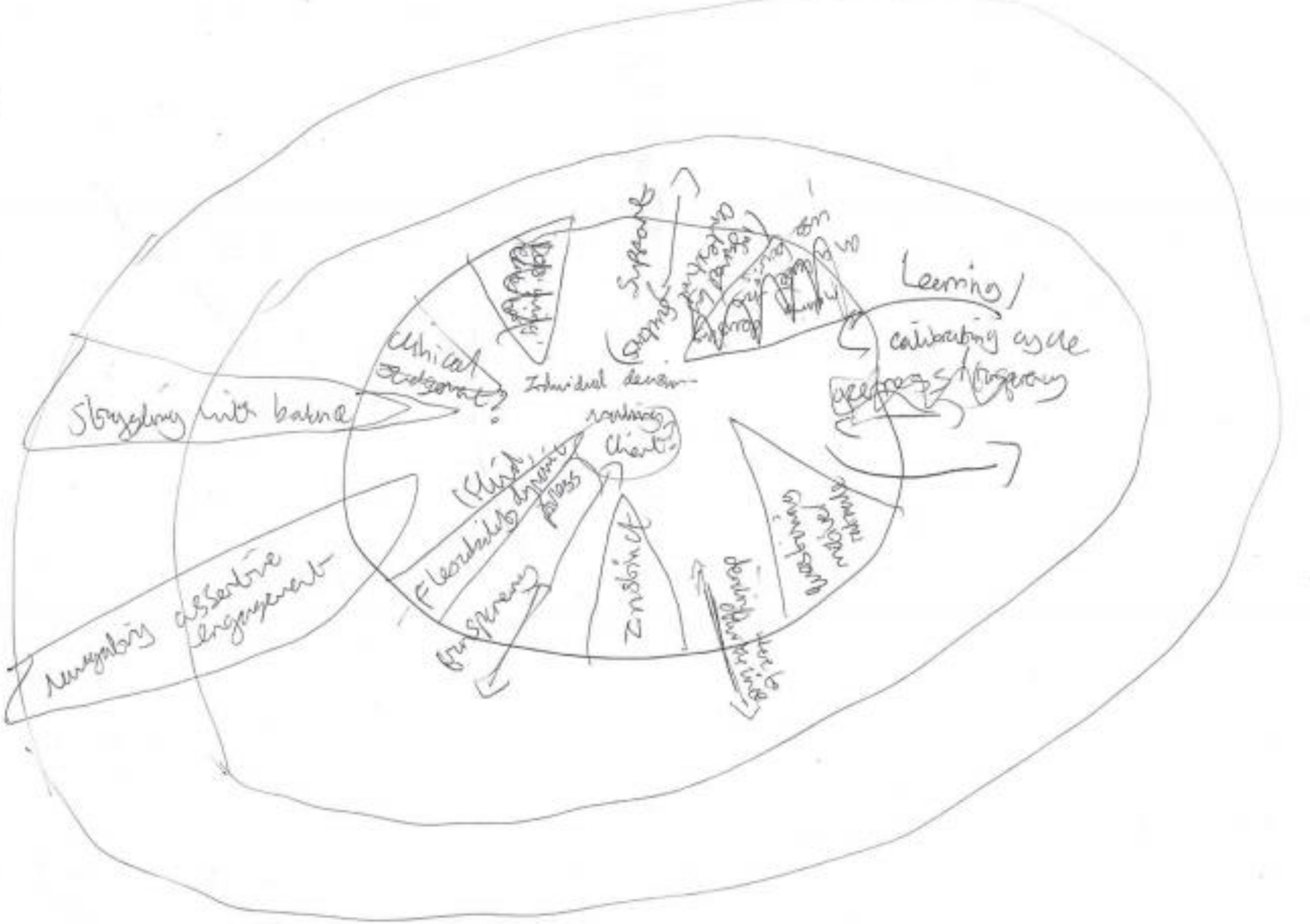


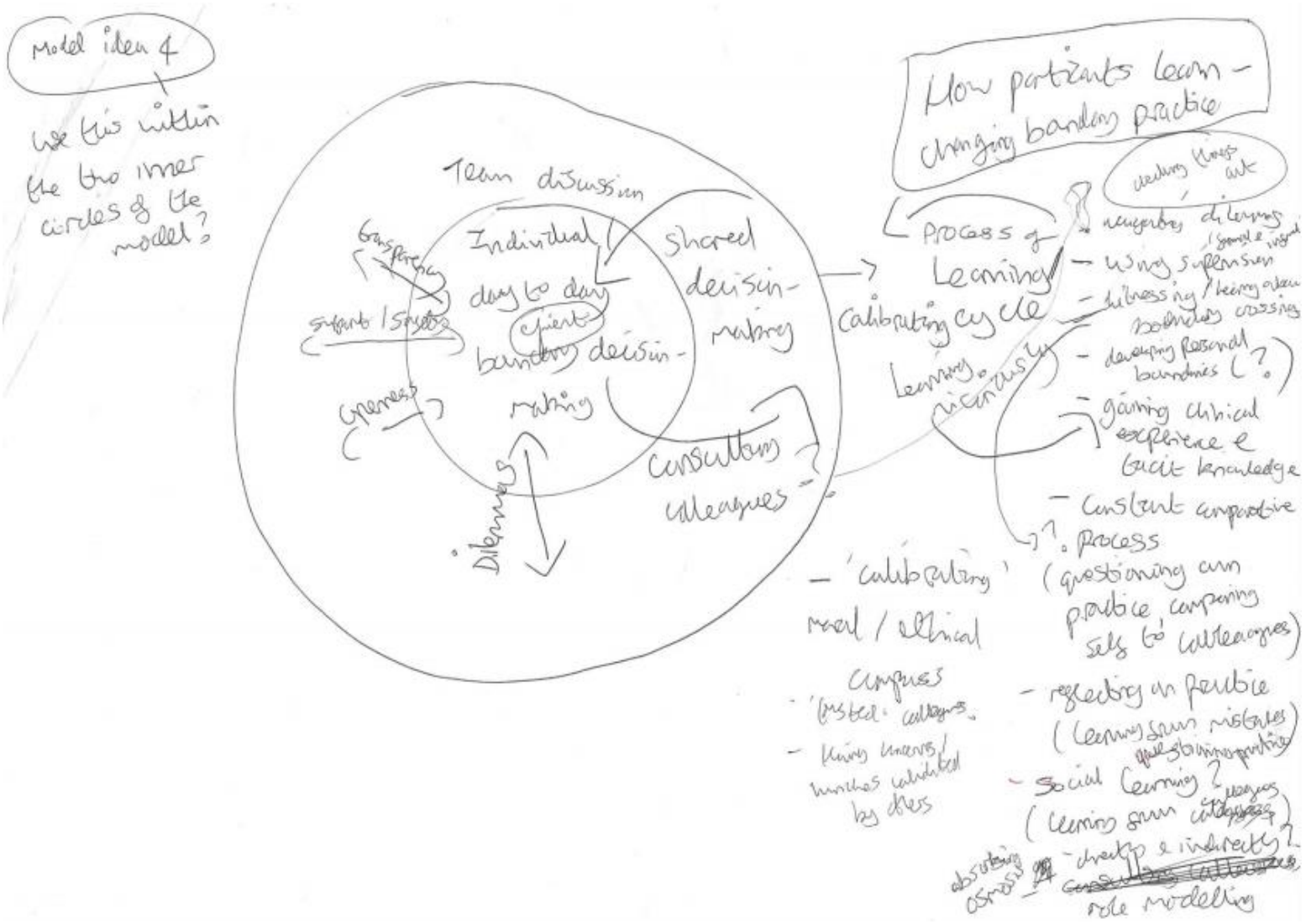
Appendix 15: Stages in Formation of Theory/Model

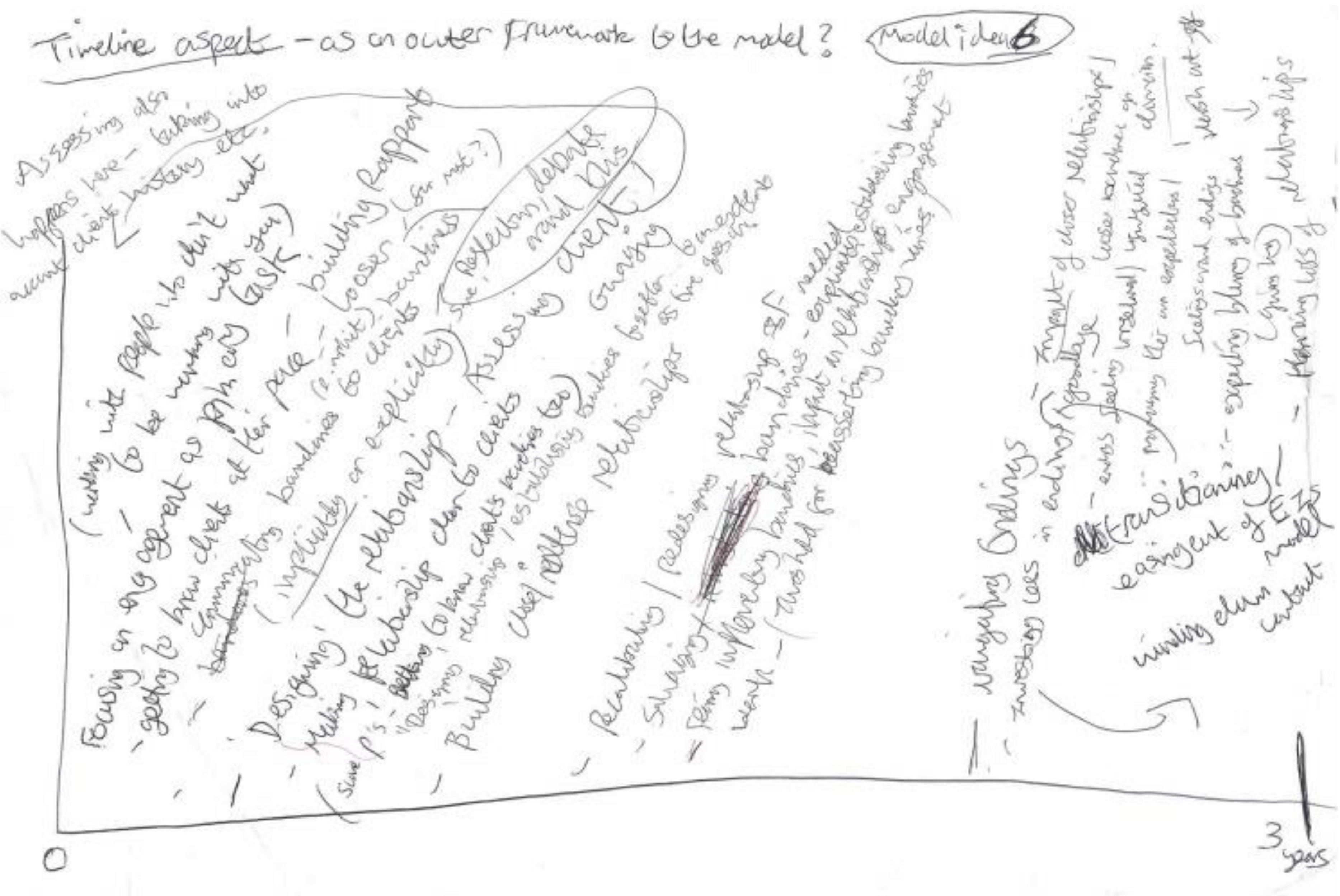

Model / Theory idea 3
context in which
Boundary decisions are made.
Covid-19 context?
Learning cycle?
* Capacity for reflecting / thinking about these boundaries influenced by team capacity (it's cognitively & emotionally draining (a burden)
- Team decision-making sits within wider EIS service culture
- assertive engagement model
- standing alongside clients
- authentic relating (humanness)
- 'Flattened' power hierarchy
- using self - disclosure?
- Building close relationships?
Where does balancing this with maintaining professional boundaries sit?
Incorporate model 2 into this?
Inner circle: Individual decision-making
- day to day boundary decision making?
(Same as model 2) flexibility
- openess, transparency with clients
- Influenced by Team discussion
Shared decision-making, enabled through openess, transparency, supportive team culture
- 'innate' / natural stance around boundaries
- Training experiences
- Individual learning / growth?
- Shaping moments
- using self - disclosure?
Individual boundary decision making is also influenced by individuals own backgrounds
"Flattened" power hierarchy / reduced power imbalance?
authentic relating
shared discussion
shared decision making
Individual day to day boundary decision making
flexibility
Navigating Assertive engagement
consulting colleagues
(but also crosses)
Creativity (uses)
Standing alongside clients
Service context & EIS culture
using self disclosure?
Building close relationships
Where does the timeline aspect sit?
who decides?

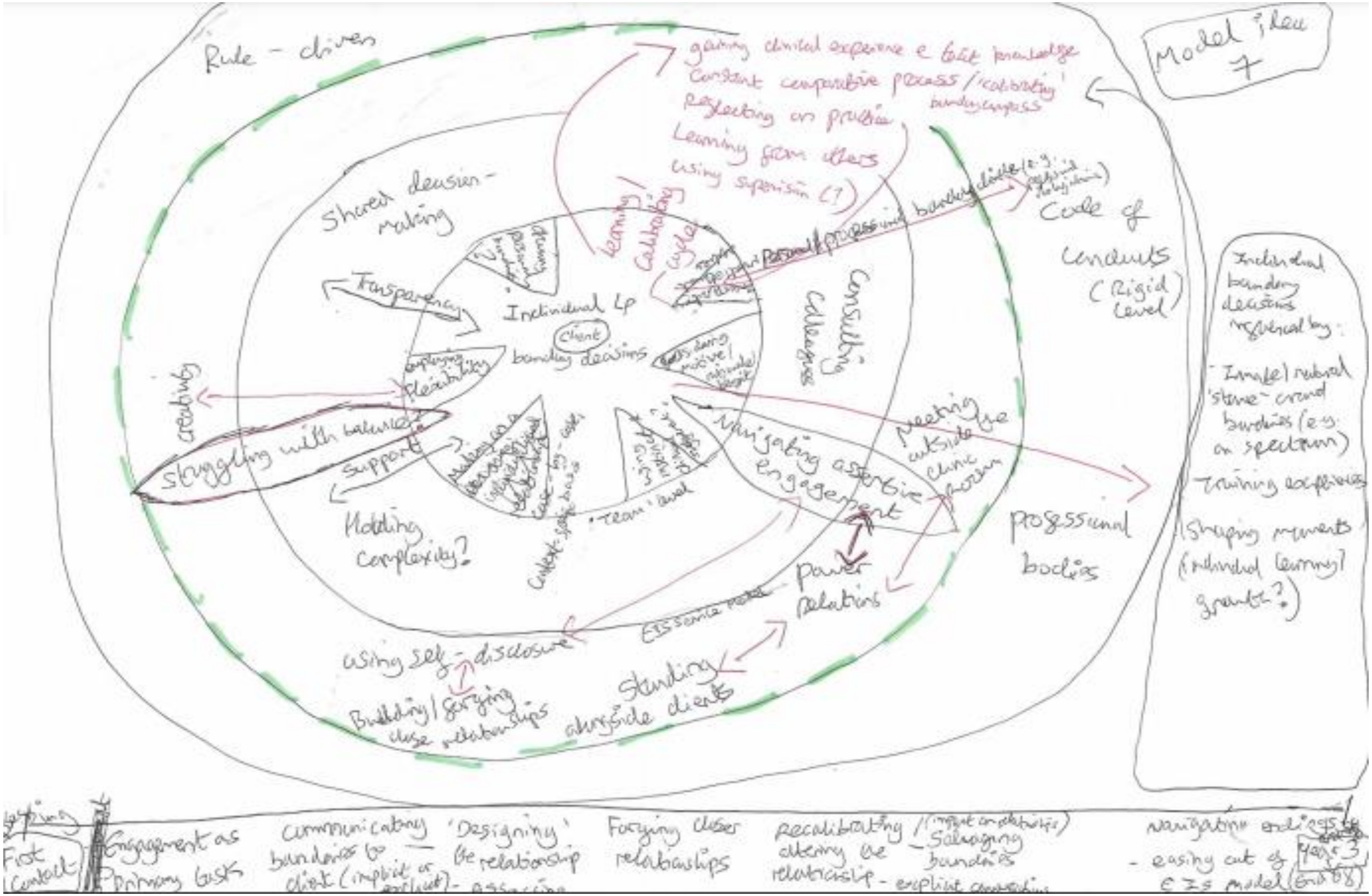
Inner circle of model

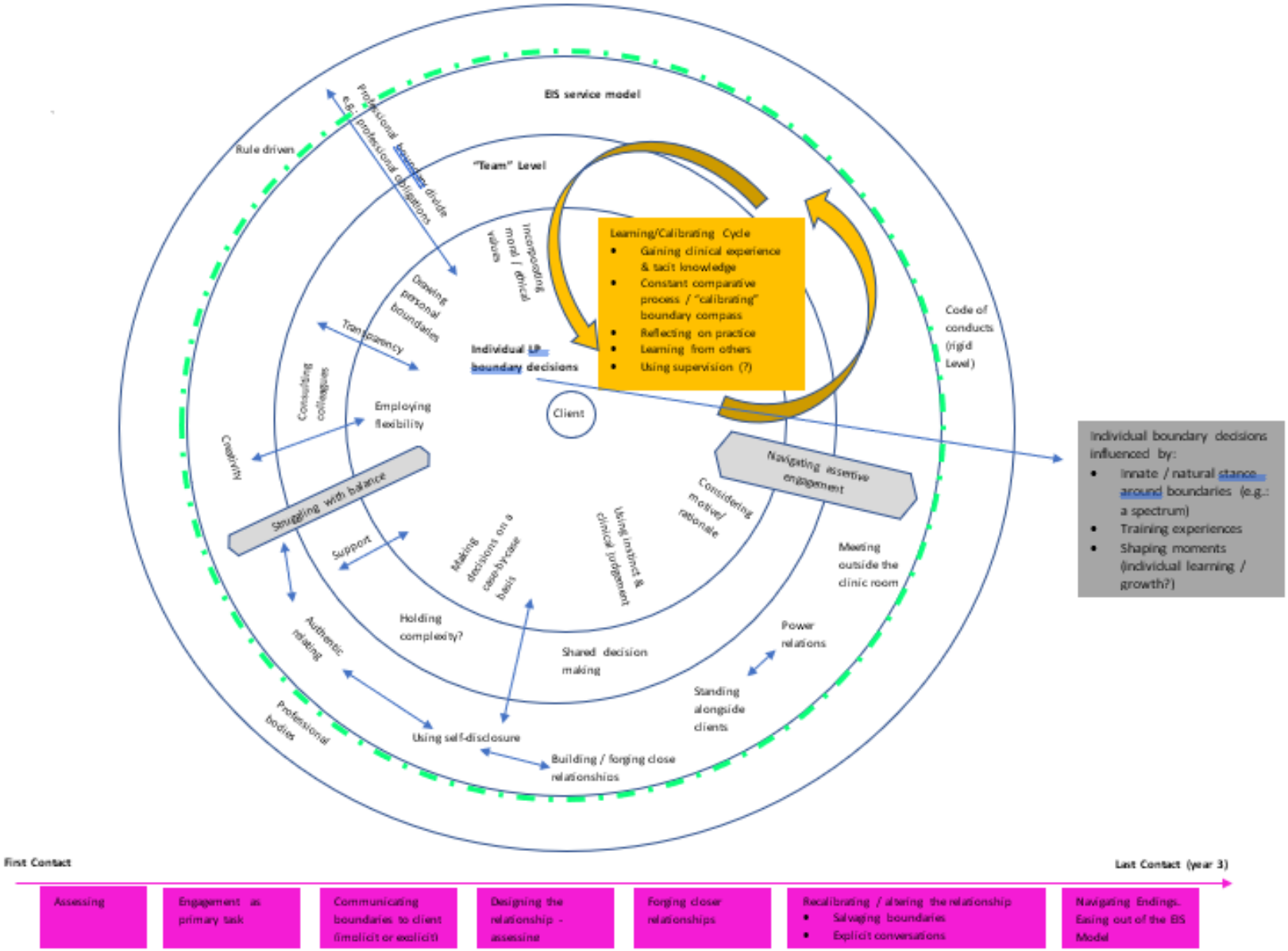
model idea 4




Model idea 4
like this within the two inner circles of the model?
Team discussion
Individual day to day decision-making
Shared decision-making
consultant colleagues
Dilemmas
Transparency
Support / Systems
Openness
How partners learn - changing banding practice
Process of Learning calibrating cycle
Learning is cyclical
- 'calibrating' moral / ethical compass
- 'trusted' colleagues
- using learning / hunches validated by others
- recognising dilemmas
- using supervision
- witnessing / learning about boundaries crossing
- developing personal boundaries (?)
- gaining clinical experience & tacit knowledge
- constant comparative process (questioning own practice comparing self to colleagues)
- reflecting on practice (learning from mistakes)
- social learning? (learning from colleagues)
- directly & indirectly?
role modelling


Timeline aspect - as an outer framework to the model?
Model ideas 6
Focusing on engagement
getting to know clients
Designing the relationship
Building closer relationships
Assessing client
navigating Endings
0
3 years


Rule - driven
Model idea 7
Constant comparative process
Reflecting on practice
Learning from others
using supervision (?)
Shared decision-making
Code of conducts (Rigid level)
Individual LP
Client
boundary decisions
Transparency
Consulting Colleagues
creating
Support
Holding complexity?
Navigating assertive engagement
Meeting outside the clinic room
professional bodies
Power relations
using self-disclosure
Standing alongside clients
Team level
Individual boundary decisions influenced by:
Training experiences
Shaping moments
First contact
Engagement as primary task
communicating boundaries to client
'Designing' the relationship
Forging closer relationships
Recalibrating
Salvaging boundaries
navigating endings


EIS service model
"Team" Level
Rule driven
Professional boundary divide e.g.: professional obligations
Code of conducts (rigid Level)
Learning/Calibrating Cycle
Gaining clinical experience & tacit knowledge
Constant comparative process / "calibrating" boundary compass
Reflecting on practice
Learning from others
Using supervision (?)
Individual LP boundary decisions
Client
Drawing personal boundaries
Incorporating moral / ethical values
Transparency
Consulting colleagues
Employing flexibility
Creativity
Struggling with balance
Support
Navigating assertive engagement
Considering moral/ rationale
Using instinct & clinical judgement
Making decisions on a case-by-case basis
Meeting outside the clinic room
Holding complexity?
Shared decision making
Power relations
Standing alongside clients
Authentic relating
Professional bodies
Using self-disclosure
Building / forging close relationships
Individual boundary decisions influenced by:
Innate / natural stance around boundaries (e.g.: a spectrum)
Training experiences
Shaping moments (individual learning / growth?)
First Contact
Last Contact (year 3)
Assessing
Engagement as primary task
Communicating boundaries to client (implicit or explicit)
Designing the relationship - assessing
Forging closer relationships
Recalibrating / altering the relationship
Salvaging boundaries
Explicit conversations
Navigating Endings. Easing out of the EIS Model

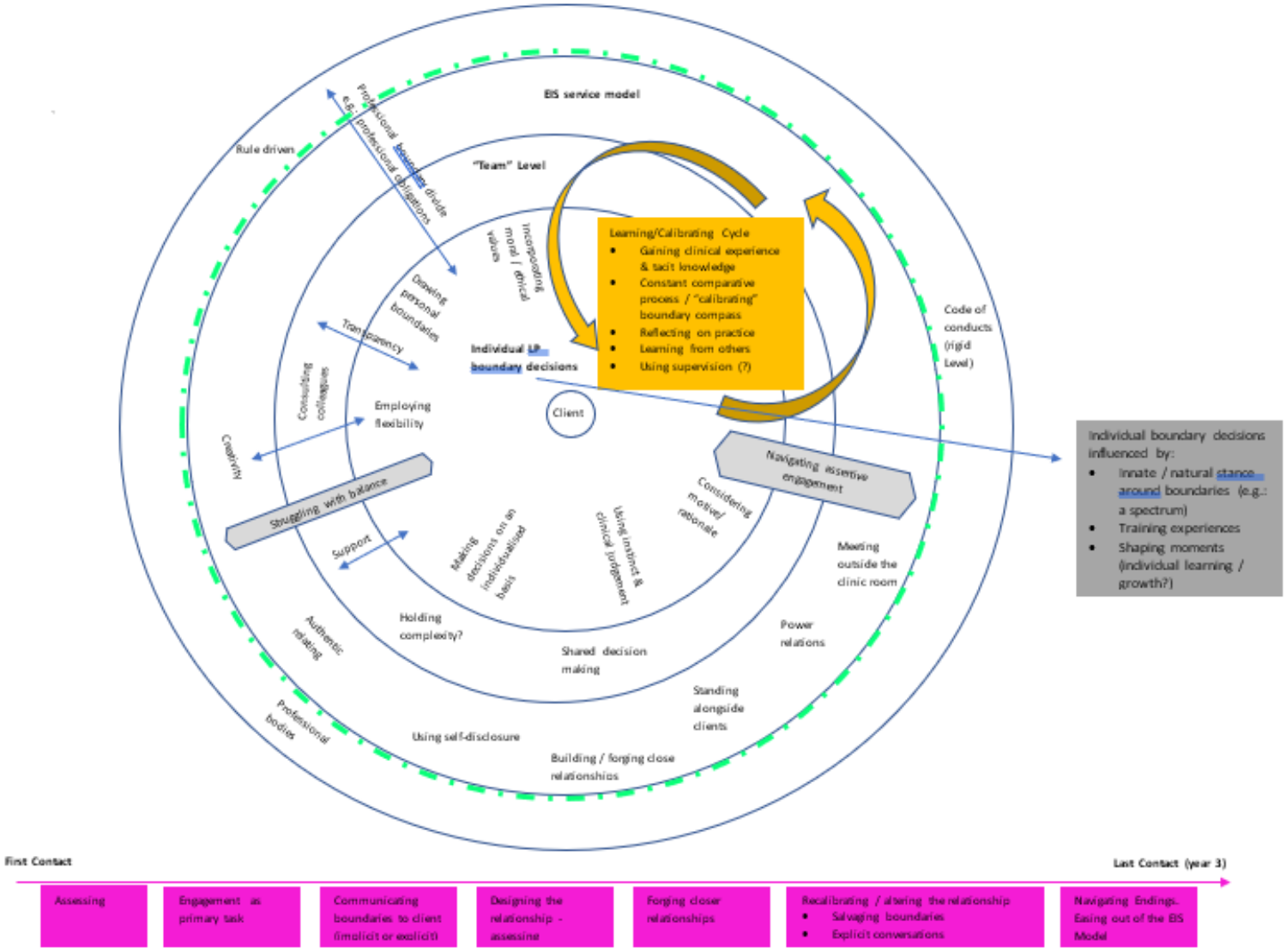
Appendix 16: Researcher Positioning Statement

Researcher Positioning statement

I am a twenty-seven-year-old, White-British female, third year trainee at the time of starting interviews with participants. I grew up in a stable, middle-class family, and I was lucky enough to have a good education, and lots of opportunities in life. I have been interested in the topic of boundaries ever since undertaking service-user involvement and co-production work when I was an undergraduate placement student in older adult mental health services. Working collegiately with clients raised lots of interesting questions and dilemmas around boundaries, and the overlapping of personal/professional lives, and it is something that has been on my radar since then.

I have a year's experience in Early intervention in psychosis services (my first-year placement), which is how I became familiar with, and interested in the boundary dilemmas that can arise when working in this model. My placement was in the same trust where I am conducting my research, and I am recruiting from one of the teams where I was on placement. I am aware this may influence my position, as it is possible, I could know a few of the participants. This could be an advantage in terms of having a good rapport with participants and them feeling comfortable and open to when discussing this topic with me (as I had good relationships with the team whilst I was on placement). The fact I have not on placement in the team in almost 2 years also means I have some distance from the team and my former colleagues. However, I am aware that there is the potential for bias on both the part of me as the researcher (wanting to think well of my former colleagues maybe) and on the part of participants (wanting me to think well of them perhaps).

Appendix 17: The Original Model



Appendix 18: Sections of Transcripts from Respondent Validation Interviews

Participant 1

Participant		yeah I thought it was good and that bit across the bottom as well that was um
Interviewer		Yeah
Participant		With the, um, the, the timeline
Interviewer		Mmm
Participant		Is great, it reminds me of that um cycle of change you know where it can, it can go right back to assessment couldn't it because of the um, if someone's in hospital or, (intake of breath) um, yeah they've become unwell you kinda sometimes you have to start all over again
Interviewer		Yeah
Participant		Um, or or move back to the engagement again
Interviewer		Mmmm
Participant		Um, and I've, I've got something like that going on, you've probably heard my phone going in the in the background that's someone whose very disappointed in me for getting them put in to hospital cause they described me as their friend
Interviewer		Right
Participant		Um
Interviewer		Yeah
Participant		And um, you know this is like that, that whole relationship thing now it's just a that's a illustration really of how it can all, come tumbling down, quite quickly cause you've got that responsibility as a professional
Interviewer		Yep
Participant		Um, and, also where you're feeding back that information to the team and, reflecting back to them about what needs to be done, and you're making a team decision and you go and do that and um, it, yeah, unfortunately it does then er, damage those relationships but it's for the, the greater good hopefully, eventually, um, it's hard to, hard to feel like that sometimes when you, you get people put into hospital and, it's quite distressing for them obviously
Interviewer		Yeah
Participant	2:49	But yeah no I think it's, I think it's really interesting to see it all laid out like this as well, because it's not (computer noise)…
Interviewer		Oh (computer noise)… Sorry you froze for a minute , I don't know if you're back

Participant You know anything like that before so, um, yeah, it's been, it's good to see it like that, I think it's interesting

Interviewer So it sounds like if, I guess if anything wants to be pulled out a little bit more it might be that, that balance or that difficulty between you know those professional responsibilities, and then

Participant Mm

Interviewer The relationship between the individuals and yeah, the the impact of that, yeah

Participant Well yeah, you're you're seeing these people more regularly, sometimes weekly for three years you get to know em don't you and then um, in a way you almost see these people more than you see, well, well actually I do

Interviewer Yeah

Participant Well especially in Covid you see, you see (laughes)

Interviewer More than friends

Participant I used to joke to them yeah I said to them that I see, I see you more than I see anyone else, you know

Interviewer Mhmm

Participant Like outside of work cause, so you do um, they, and they start to see you as sort of an equal, don't they, um, but then when stuff happens, and they're putting themselves at risk or, and they don't have any insight you've unfortunately got to take that um, take that step

Interviewer Yeah

Participant And also in situations where you're just pressed for time whereas like, I had it yesterday, when afterwards I put the phone down I felt a little but bad and I'm sure they didn't feel um, think anything of it but, I was making a call between visits and was very busy and I had to keep it very short whereas they wanted to talk and

Interviewer Yeah

Participant You know you almost feel like you're, you're you're kind of um, sending mixed signals to them you know

Interviewer Yeah

Participant I, I called them back later to apologise, to make myself feel better

Interviewer Oh yeah, it's so tough though, isn't it, you're

Participant Yeah, it's the way it is, isn't it

Interviewer Yeah

Participant Yeah

Interviewer	Yeah definitely. Oh well thank you very much that's really useful feedback, I'm glad it's good
Participant	That's alright
Interviewer	To see it and it makes sense laid
Participant	Yeah
Interviewer	Out like that
Participant	It does. Definitely definitely it's really good and it's um, be really useful to see how that evolves and, when you get your work published, how it um, gets absorbed in
Interviewer	Yes!
Participant	To a,
Interviewer	Yeah
Participant	Into the services. When do you finish your, when is it due in?

Participant 9

Participant	Yeah, it makes, it makes absolute sense, um …. It's quite, it's quite a challenge to capture something so complex and kinda nuanced in a model, isn't it?
Interviewer	Yep
Participant	Um, but I think you've done that well, um …
Participant	…. ….. I spose if I was looking at it and I, had no prior knowledge of the of your study I wouldn't know what it was about really
Interviewer	Yeah
Participant	Um
Interviewer	That's fair (laughs), yeah
Participant	Um, so … yeah maybe like a big title
Interviewer	Yep
Participant	But I think… I like that it's sort of yeah it's sort of like… yeah circ circles that are coming out, from client um
Interviewer	Mhm
Participant	… um … professional code of conduct… … So this, the learning curve rating circle that's for that falls within EIS and us between team EIS and clinician

Interviewer	Yeah I, yeah that's where I've got it at the moment but that that can be, that can be moved around… Would you, would
Participant	No, I think that's, I think that's, I think that's right where it is
Interviewer	Ahmm, okay…
Participant	Um…I would say yeah it's hard to critique it really
Interviewer	That's alright
Participant	No I think, I think it, when you talked through it I felt myself nodding and thinking yeah that, that's that's reflective of I think what we talked about and … yeah, my experience of of boundaries I spose it's so, but I think you've captured this as well it's so, it's so case by case.

Participant 9

Participant	So I wonder if the client bit in the middle
Interviewer	Mmm
Participant	Cause, we're sort of I think when you kind of navigating boundaries
Interviewer	Mm
Participant	Some of that is also dictated by, the client's own boundaries too
Interviewer	Yeah, that' a very good point, yep
Participant	And I wonder whether there's, cause everyone's ever client is so different
Interviewer	Yeah
Participant	That I think we, it's sort you know, it's always it's almost a bit of a dance between the two isn't it between clinician and client and I think
Interviewer	Mmm
Participant	I spose the model… kinda represents the, the boundaries being kind of influenced by the clinician and the, the wider system and I suppose
Interviewer	Mhmm
Participant	The client also has some influence over the boundaries too
Interviewer	Yeah, I think that's a really good point, and I think I can probably, um, well (a) I can add in a bit into that centre circle with client that kinda represents maybe their, their wishes, and maybe do some like arrows that have, you know, different one at both ends to show that that's going both ways maybe?
Participant	Otherwise I think it's really interesting and it's a, it's a, model that can be reflected on, um… Be a really useful tool for reflection, um, within a team

Interviewer	Yeah, I think that's my hope as well that it can be used to kinda think about okay well, where are these different elements and, where do we sit on them and what are are influences going on and all that kinda stuff, yeah
Participant	Cause there is also I guess I mean you can go on, the circles could go on couldn't they, you could, you could it could be never ending
Interviewer	Yeah, societal levels
Participant	Societal, cultural, you know
Interviewer	Yeah
Participant	It's so many, there's so many influences there
Interviewer	Yeah, that's a really good point
Participant	Lived experience
Interviewer	Yeah
Participant	Um, all, you you know um, oh, so many you, you could continue with it for ever
Interviewer	Yeah
Participant	I spose it's hard to hone it down isn't?
Interviewer	It yeah it was difficult that is why it's complicated cause there was just so much I refused to cut out, sort of thing
Participant	Yeah
Interviewer	But um
Participant	Yeah, no you did a great job
Interviewer	Thank you Very much, that's so useful, any, anything else, um, before I
Participant	Not that I can think of, I don't know if there is any way of simplifying it so that it's sort of, it can be something that's used
Interviewer	Yeah
Participant	But I don't I don't know that you you can, it's hard to do that without losing all the …
Interviewer	Bits
Participant	Bits yeah
Interviewer	Yeah yeah. I'll definitely give that a go, and try to simplify it down a bit
Participant	Cause there are so many threads is'nt there um, but no I, I thought it was really interesting and I, yeah it definitely relates to EIP I think, I think… it really fits with EIP
Interviewer	Yep, it is, it is EIP specific

Participant	Yeah
Interviewer	So yeah, it's not
Participant	Much EIP driven
Interviewer	Mmm
Participant	Um… yeah, so interesting, thank you

Participant 11

Participant	I think it's I mean it's really it it's impressive it's quite nice to see it like that, to see, to see this kind a quiet complex like… it's not, yeah it's not something that I've, sort of thought about that much in terms of having it defined, and it's quite nice to see it in a sort of, defined way
Interviewer	Mhmm
Participant	That, that also, you know you can you can see the movement in there, the the movement between the different areas so that's nice
Interviewer	Anything else that, that you're not sure about, that you would change or move around
Participant	Ohh err… Was there anything about families that came up?
Interviewer	Well that's a good point so it did, it did come up um, it wasn't I guess one of the main themes, because with grounded theory
Participant	Yeah
Interviewer	Eventually, you have to decide what you let go, um, in terms of what
Participant	Yeah yeah
Interviewer	Actually isn't um
Participant	So the families got dropped, yeah
Interviewer	But
Participant	Yeah
Interviewer	If, it is definitely something that I can revisit because there was stuff about families and there was stuff about you know, those, that difficult boundary decisions, when how much you're sharing with families and, how much when clients do or don't want you to share with families as well and the position that that puts you in
Participant	Yeah
Interviewer	What would have been your initial thoughts?

Participant Yeah

Interviewer About families in this context?

Participant Well it it just feels like I mean when you were talking it was when that bit down below

Interviewer Yep

Participant When you were talking about negotiating the boundaries like, often we're negotiating, like as well as negotiating the boundaries with the client we're, it's like, you might have parents that just really kind of intrusive and you kind of

Interviewer Yeah

Participant You know in an ideal world I mean, you you know different people have a different approach to it but it's like, sometimes it's really appropriate to have the parents totally involved

Interviewer Yep

Participant In everything

Interviewer Yep

Participant And then, there's other times, and more often, you kind of, you kind of don't want the parents there at all, like, you need a boundary between the parents and the client like in order to be effective

Interviewer Yeah

Participant It's just, I dunno I obviously didn't ever think about that I think when, when we were talking about it but um, well I mean I guess, yeah, it's just sort of yeah you've got so many things in there but but

Interviewer I

Participant It's, yeah it's just a different dimension isn't I spose it's like, we quite often have contact with families and it's, yes, I don't know where it would fit in the model

Interviewer Yeah

Participant Cause it doesn't just neatly fit inside the client's circle, or even just outside it, it's, it's sort of like separate, it's a separate thing

Interviewer Yeah

Participant But

Interviewer But I guess it could it could be something that is incorporated into the timeline potentially, um

Participant Yeah

Interviewer And, it it could be something that um, I guess could, could come into the EIS service model level potentially, cause it is

Participant	Yeah
Interviewer	A big part of the, you know service ethos as well
Participant	Yeah
Interviewer	Working with families
Participant	I think that might be yeah, that's probably the most like, easy to fit in there without much explanation
Interviewer	Yeah, yeah
Participant	Spot
Interviewer	Yeah
Participant	You know they're just like working with families, I don't know but if it's not come up in your grounded theory you know, the research then it's not come up, it's it's um
Interviewer	But but part
Participant	I think it's missing there
Interviewer	But part of this process as well is also to see what participants think about the model, and what they think might
Participant	Yeah
Interviewer	Be missing that should be there, so that you know
Participant	Yeah
Interviewer	Within grounded theory if things come up there, then you've got justification or validation for putting them in, if that makes sense, um
Participant	Yeah, okay
Interviewer	So yeah, I can definitely use that
Participant	There's also there's a question of like, are you working you know, you know the extreme family approach, and with some families that I work with I'm basically working with that client and their family like
Interviewer	Yeah
Participant	There's not really much distinction between the client and the family they are, there's not much boundary between the two, they are
Interviewer	Yeah
Participant	One and the same
Interviewer	Yeah yeah
Participant	And, it's like, work out that that is the most appropriate way to work with them

Interviewer	Ahum
Participant	And there's other clients where I am like, I wanna get this family out of this picture like, I can't, I can't even like I just need them gone to be able to do my work like it's too
Interviewer	Yeah
Participant	It's too intense, I can't work with them, with that family so I
Interviewer	Yeah
Participant	Where I need to put the boundary is, outside and protect, um, protect the family

Participant 11

Participant	I think that's, that's fine I yeah struggling with balance
Interviewer	Mmm
Participant	I'm not sure about that you know, that struggling, it's sort of
Interviewer	Yeah
Participant	It sounds a bit overwhelming
Interviewer	Yeah
Participant	But it's like, that's kind of I dunno for me it's sort of, it feels like that's part of the excitement of it in a way it's like what keeps you alive and it's kind of, it it's what keeps it dynamic it needs to be dynamic and moving and balanced you know to sort of like that all the time
Interviewer	Mhmm, yep
Participant	It's never, just fixed and and, and yeah so yeah managing or I dunno I don't know what the youuu rrr it's just it's just, struggling just feels a bit
Interviewer	Yeah
Participant	Like it's just hassle all the time I'm always trying to keep balance and it's overwhelming me
Interviewer	Yeah that makes a lot of sense, so yeah have a think about that wording yeah, cause yeah I'm yeah I know I think I've just put managing in there as an alternative but
Participant	Yeah
Interviewer	I know what you mean
Participant	Yeah yeah
Interviewer	You're after perhaps something that is a little bit more positive and ex-exciting exciting sort of thing, yeah

Participant	Yeah
Interviewer	Okay
*Participant	It's almost like I mean I was I thought navigating was a good word as well but it's not quite navigating cause you don't navigate balance but it's like, it's almost like maintaining balance
Interviewer	Mmm
Participant	Or or but then maintaining is a bit dull I dunno, there's something more, I dunno, something more active
Interviewer	Yep
Participant	Active and alive somehow that that kind of like
Interviewer	Yep, okay, great, that's really good, thank you. Anything, anything else? That you were drawn to or, would be good to comment on?
Participant	…Um… no I don't think so, I think everything else is there, yeah, no, I think I think it's yeah it's really good it's a, I appreciate that that, there's a lot of work and talking to people and then like, analysing what they've said and like trying to find the patterns and like yeah I mean I'm really impressed it's like. there must be um, yeah, they must of there must be a lot of trawling through, it represents a lot of trawling through and it's, yeah, but nice to have it and it in a kind of contained, um, little visual, visual thing that's like, er got the main points, it's lovely

Appendix 19: Learning and Calibrating Cycle

This cycle represents the process and means through which participants learnt more about navigating boundaries. This cycle spans multiple layers of the model, as whilst learning occurred at the individual level, this took place through team processes, and the lens of EIPS culture. The cycle is depicted on the following page

Gaining Clinical Experience & Tacit Knowledge

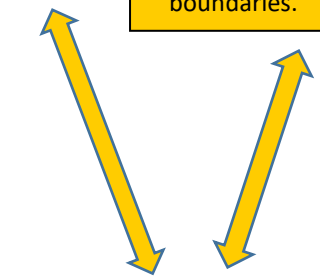
- The most obvious way through which participants learnt more about navigating boundaries was through gaining more clinical experience:
- encountering more boundary dilemmas within EIPS and experiences where flexing boundaries had been beneficial, thus gaining confidence in flexing boundaries, and tacit knowledge regarding where the line needed to be drawn.

Constant Comparative Process / "Calibrating" Boundary Compass

- Participants compared their boundaries, and practice around boundaries, to their colleagues.
- If they were unsure or had a boundary dilemma, they would often question whether colleagues would have handled the situation in the same way, or they would seek out colleagues whom they respected, or who they thought navigated boundaries well, in order to discuss their thinking and "calibrate", or "recalibrate" their boundary compass, checking out their clinical judgement.
- Related to this, many participants expressed the wish for colleagues to recalibrate them, if their colleagues felt they were making unwise decisions around boundaries.

Reflecting on Practice

- Participants engaged in reflective practice to help them think about, and learn from boundary dilemmas:
  - reflecting on the impact for the client -participants motives (conscious and unconscious) and whether these were justified.
  - other ways in which they could have approached the dilemma
- Often this was self-reflection, or through a conversation with another colleague or in supervision (linking to the other subcategories).
- some teams had reflective practice groups set up, within which participants reflected on boundary dilemmas. Some participants who did not have access to a reflective practice group expressed a wish for this.



Learning and Calibrating Cycle

Learning From Others

- Participants learnt from colleagues in how to navigate boundaries, both directly (through conversations and team meetings), and indirectly (through role modelling).
- For participants qualified less time, often this was from more experienced colleagues, although even those qualified a long time felt they learnt a lot about navigating boundaries from other professions within the MDT, such as peer-support workers, or psychologists.

Using Supervision

- There were some mixed opinions on the use, or helpfulness, of supervision for navigating boundaries.
- Many experienced supervision as valuable for discussing boundary dilemmas, and noticed a difference in how meaningful it was in comparison to other clinical settings they had worked in (where it had felt more of a tick-box exercise).
- Others still felt supervision had a formal, tick-box quality to it, and for idiosyncratic reasons (such as more pressing matters for supervision, or they and their supervisor being in quite different places along the boundary spectrum), some were more likely to turn to respected colleagues for informal supervision regarding boundary dilemmas, rather than using their formal supervision.
- It was also felt that, given the EIPS model, in which team discussion, transparency and shared decision making are such key principles, boundary dilemmas were more likely to be discussed and mulled over with the team before individual supervision occurred anyway.

Appendix 20: Supporting Quotes for all Categories and Subcategories

Professional/Organisational policy Layer

"*I face boundaries more on my professional registrations…I'm led by those really*" (Participant 12)

"*you're a professional even when you're not at work and there's all these expectations from…our governing board NMC and that's a…really strange concept that I'm really very uncomfortable with…your professional boundaries override your personal boundaries almost*" (Participant 6)

"*Some things are clear cut…if your client asks you out for a date…that is just no way*" (Participant 12)

"*you're a professional even when you're not at work and there's all these expectations from…our governing board NMC…your professional boundaries override your personal boundaries almost*" (Participant 6)

Following policy/codes of conduct

"*I know the policy…it's...how much you can bend the rules…we don't tend to follow things to the letter, but we know what's… underpinning everything…whether you are going to um, exactly abide by those rules is a different thing and, I know everyone's the same there*" (Participant 8)

"*If I told somebody from a risk assessment…"what you used somebody else's bike and you didn't have a helmet"…all the sort of things that I can say…I'm managing my own health and safety are not there, but…I know as a person I'm confident…riding a bike, I'm confident that I can separate, if I fell off that bike or something happened ,that I would just deal with it*" (Participant 11)

"*the use of WhatsApp's is quite an interesting one because, it's, it's not really supported by the trust…because of kind of data protection…but if it's…a service-user's preferred…perhaps only method of communication, say they haven't got credit…And they like WhatsApp then, it is something that I have used with people."* (Participant 9)

"*You know that it's probably outside the realms of…usual professional conduct…the dent…does that mean you've broken a boundary or does that mean you've…manipulated a boundary*?" (Participant 12)

"I often sort of som, sometimes sort of self-deprecating and say to people, "you may not like me asking you this but it's part of my job description to ask you "blah, blah, blah" (Participant 4)

"*thinking about different roles. I think it can be easier or more difficult to set those boundaries…when you're a lead practitioner and…you're care planning and…in a way that can be challenging in terms of the therapeutic relationship sometimes because you're having…To do some of the kind of more statutory stuff…but it actually also sets…there's a certain boundary, it kinda sets that boundary level as well?"* (Participant 10)

"*you're a professional even when you're not at work and there's all these expectations from…our governing board NMC…your professional boundaries override your personal boundaries almost*" (Participant 6)

"*my safety does stay in the back of my mind, even now*" (Participant 5)

"your job is at stake and potentially you're lively- you know, everything else in your life…having that sort of background to it all…underlying it, is helpful to me" (Participant 1)

"What would happen if this case went to Coroners Court-there's such an emphasis on kind of not losing your pin…it's much easier to have a clear black and white boundary" (Participant 6)

"It just makes you more aware that…we're under the spotlight quite a lot…and there's potential for things to go seriously wrong….when I was doing my nurse training, they made us read through the NMC hearings?...To see what, what you could get taken to a hearing for?..you've either got medication errors and people have tried to cover themselves…Or you've got people that have got in relationships or broken boundaries with service users, and that drills in to you I think that um, it's, you know it's, you've got to take it seriously" (Participant 1)

"our own personal and professional boundaries…perhaps we…hold our own boundaries in higher regard almost…Subconsciously" (Participant 9)

"If someone was offering you, I don't know…money or something big then…that's quite often what I do "oh, I'm not allowed, I'm really sorry, we're just not allowed I'll be in trouble" (laughs). I kind of…blame it on the system" (Participant 10)

"I'm well aware that, that I wouldn't want to be in a position where- someone, is dependent on me as an individual. I'm always very mindful that I portray myself as a representative of an organization that has out of hours support and a duty service and all of that kind of thing" (Participant 4)

EIPS Culture Layer

"if I had stayed in a very, very strict boundaried way…I'm not sure that would work in early intervention services…it would be hard to sustain for very intensive, um regular contact with the client over a period of years. For them to kind of not feel that they know you in any other sense than the person who asks them questions about what they're doing but never, never shows that there's more to them than…this, professional front. And that…would affect umm engagement" (Participant 5)

"*boundaries wasn't…a dirty word anymore"* (participant 6)

Navigating assertive engagement

"we invest a lot of energy into the engagement, early engagement" (Participant 9)

"We tend to be working with people who don't really want us to be working with them at the beginning" (Participant 6)

"when you're trying to work hard to engage people…you also have to work hard to keep your boundaries in place" (Participant 12)

"*Often we're working with…people who may not…want to work with us…they don't perceive there to be a need or, or they feel quite frightened or suspicious or paranoid"* (Participant 9)

"when you're trying to work hard to engage people…. And this was my experience in forensic services and this one…When you work hard to engage them, you also have to work hard to keep your boundaries in place" (Participant 12)

"you, focus on the engagement first and the boundaries second" (Participant 6)

"*You can't keep doing it, or…we're in har-harassment territory…just to keep going back and back and back…you've got to have a clear reason of why you're doing it, and you know when will you ever stop? do you just keep doing it forever and ever?"* (Participant 13)

"*we actually mentioned today about giving someone therapeutic space…holding your hands up and saying, okay actually, am I…trying to…see this person for my own reassurance…it's about discussing that as a team and saying, no that person can have some like therapeutic space…I think…we always want to be actively doing something, um, but is that in itself kind of, pushing the boundaries a bit?"* (Participant 2)

"If they absolutely do not want to share something with us, do not want to work with us, then that's their decision" (Participant 5)

"*they felt that we had really overstepped the mark in terms of boundaries…like coming, turning up unannounced to my house…in the middle of a pandemic, how dare you…the service-user's boundaries have been pushed…Because of our sort of prerogative and our agenda, when actually…maybe our perspective on what's needed is just not aligned?...that has damaged the relationship…and perhaps damaged their future engagement with us*" (Participant 9)

"*Do we arrange to turn up at your house?...do we just turn up at your house…without arranging an appointment…how do we engage…so we have to sort of make those decisions and judgments…depending on the individual*". (Participant 11)

"*Knowing where you're being assertive…where the border is to where you're then harassing them"* (Participant 7)

"*perhaps we…encroach on people's boundaries…with good intention, but…perhaps our service-users don't always feel that their boundaries are being, um, respected*" (Participant 9)

"*that brought up a little bit of tension for me of, obviously we're all doing this within the frame of …really wanting this person to lead the life they want to lead…and wanting them to be safe. And I guess that's where the, you know…no-one imagines that the life they want to lead involves us turning up at their house if they've said, no, I don't wanna talk to you…So then balancing that with then well are they safe…that feels really…like a blurring of of, of boundaries which I think is necessary"* (Participant 6)

"*how many times has this person been seen…what is the risk?...what is their situation…if it's very, very clearly…deteriorating then…it's the rationale…If you've got a very clear sound clinical judgment and rationale of why you're doing it…Then fine but… "oh he's not engaging" isn't good enough*" (Participant 13)

"if someone's telling you "I don't want…to be involved with your service" but you feel that you've got a duty of care to…offer them support" (Participant 7)

"*I've had people say…" I'm just shitting myself that someone else is gonna take their life"…it brings up lots of different ideas about boundaries and about how we view, from our own internal…make up of what we've experienced*" (Participant 13)

Meeting outside the clinic room

"*We can meet people in a, in a bit more of a, um, normal environment…in a coffee shop they would normally go or, go for a walk in near where they live or something I think it just really does help…People feel more normal and feel like we're kind of on their side a bit more?"* (Participant 3)

"*It's kind of doing what you can to get alongside somebody and giving them some power in their own decision-making about where you meet them. That's, that's a small token of something*" (Participant 5)

"*we've done things like a woodland group…you get involved in sort of building fires and whatever making stuff…they're doing a tennis group at the moment…but I think it's okay because the boundaries are contained within that situation*" (Participant 3)

"we're *a bit more…get to know them, get them to know you and, come out for a walk or go to a café…rather than sit in there and doing that…narrow view, clipboard stuff*" (Participant 1)

"we ended up going for a run together because that's what I was really interested in and that's what she was really interested in" (Participant 6)

"It was obviously really important to him…and I enjoy a bike ride as well myself" (Participant 11)

"Other people are completely oblivious to it and I'm like, ahhh, I think we should, you know le-let's just, so I, I, I might, roll generally with that, as to try and like keep the conversation, you know, it's to keep it discreet, so I'm always thinking about yeah who's around at this time and who's, who's listening in on this and it doesn't matter whether they, you know, don't know anything it's just like it's, it's none of their business so, it it's sort of, keeping that there" (Participant 11)

"one of his goals really is to gain weight. He's quite underweight? *So we started going to sort of cafes and get-getting a bite to eat. And then, sort of more recently he said, ah well could we not, you know, I might get a beer, might get a few beers in. Um, and I'm sort of thinking well, you know, ideally it's, it's not, it wouldn't, ideally you wouldn't be drinking alcohol when we're meeting up because it feels like perhaps that's overstepping some sort of boundary (Mhmm mhmm) Some unwritten boundary about, you know… but then equally it's his life you know, and if he wants to get a beer, why not? So it's sort of and if that's, if that's meaningful to him and he you know, that's his only social interaction with somebody and he wants to get a beer, then it's not really my, is it my*

place to be saying, whoa whoa, you know, boundaries mate, you mean, we, you shouldn't be drinking alcohol when you're meeting up with me as a professional, you know…this person's…living out in the community…they're able to make those decisions…they've got that capacity…I think what I said was, um, ideally it'd be nice to catch up with a clear head, (laughs) but it's up to you, I'll leave, I'll leave that decision up to you. And he said, "oh go on I'll just have a half then" (Participant 9)

Levelling Power Relations

"*you see people in um, their homes, there's a difference in power? Suddenly there there's a bit more kind of levelling of that, that power?"* (Participant 10)

"*Whichever way you look at it, it's still an authority professional figure…That does have power…I.e. you can trigger Mental Health Act assessments…get you to take meds, has privy to all your personal information… So, whichever way you look at it, even if the hierarchy is a bit more flattened…there's a big power differentiation*" (Participant 13)

"*someone has told me that they were literally going to kill someone…And they told me that knowing that I would act upon it…and…we watched Cash in the Attic together whilst we were waiting for the AMHPs to come*" (Participant 4)

"*the whole point of what we're doing is to engage people…you're trying to minimize that power dynamic as much as you can…it's never gonna be an equal relationship because…Of the set up, but if, if both people are aware of what the point of the relationship is and are happy with that"* (Participant 6)

"*having that open conversation about, you know, I'm aware that there's boundaries in between us you know, how do you want that set up…you know be open and honest and transparent about the fact that we need to have boundaries…but actually, how do you find that and what do you want"* (Participant 3)

"I think a lot of this falls back to sort of the power, really, and the concept of sort of the relationship being actually inherently quite imbalanced…Whether we like it or not…it is an imbalanced relationship because, you know we have, we have a sort of, a clinician or a professional coming in and, and, sort of, assessing and asking questions and, and then there's sort of a sense that, that we have to maintain our sort of conf-our professional boundaries and not disclose too too much…So that must feel quite exposing and then for me to sort of say, well no, you can't have a beer, who am I to tell someone that they can't have a beer, you know?…this person's…living out in the community…they're able to make those decisions…they've got that capacity…I think what I said was, um, ideally it'd be nice to catch up with a clear head, (laughs) but it's up to you, I'll leave, I'll leave that decision up to you. And he said, "oh go on I'll just have a half then" (Participant 9)

"*It's kind of doing what you can to get alongside somebody and giving them some power in their own decision making about where you meet them. That's, that's a small token of something*" (Participant 5)

Inviting authentic relating

"*I think there's definitely an aspect of thinking, well…if I'm just gonna be this professional, um then why should you be you, you might as well…play the role of a, a patient kind of thing*" (Participant 7)

"*you're doing quizzes together so one, one practitioner might be doing the quiz and then the other practitioner's joining in and doing it…you have a bit of a…laugh about how good you are at answering the questions…and they get a bit of insight into your…. Weaknesses*" (Participant 3)

"*I might say "oh I understand how you feel, you know, I can-can completely relate to that" but I never ever go into details…but at least they can see that we're human?…we're not just robots and that we don't just sit here and go, "oh, okay" you know*" (Participant 3)

"we quite often had people in cars, that's when the boundary situation changes a little bit? Because you you know, when you're having a meeting with someone you kind of have a bit of an agenda don't you generally, and it's sort of what, what's it gonna be about, but when you're in a car with somebody, that goes (yeah) And I think that's the time, you you end up having conversations with people generally about stuff" (Participant 3)

"actually, in those sorts of conversations, that sometimes are a bit, um, non-scripted? if you know what I mean? (Yep, mhm mhm) You go in, do your visit, and on the way out it's the kind of you know (Chit chat) Oh, look, your mum's just (computer noise), yeah. And, that part of it sometimes can be really valuable, really rich" (Participant 13)

"I think it's difficult again because of our approach is so personable that suddenly five o'clock comes and we, it, it seems like we don't care (Yeah) Kind of thing, our phones off, you can't call me (Yeah) It's past 5 o'clock. And um, there's even been an occasion where I know of that a colleague has been forcibly kept in someone's house, beyond 5 o'clock, or not forcibly, but coercively requested to stay in someone's house after five to prove that they care?" (Participant 7)

Building close relationships

"*we want to work with them on their terms and… <u>our</u> job description is to help <u>you</u>*" (Participant 4)

"*the way that we can meet people…in a coffee shop they would normally go or…for a walk in near where they live…it just really does help…feel like we're kind of on their side a bit more*?" (Participant 3)

"*we've been on a journey here…And I've seen you grow…a couple…they were street homeless…we've been able to support them with housing and, employment and, getting their driving licence back*" (Participant 9)

"*I like to…support people and…stand by them…rather than telling people what to do"* (Participant 2)

"it's quite hard to not get in touch?... normally I would be speaking to her…I'd have it in my diary that I'd speak to her once, but we'd inevitably speak a lot more than that or text or message or email" (Participant 8)

"this is someone I feel very comfortable with. We talk about music, we talk about football, we have a we have a very relaxed and informal relationship…over the last seven days I've had to meet him and say, I'm really sorry mate but your family are concerned about you, frankly, I'm concerned about you…that's not been made any more difficult or any worse by having built up a strong rapport with him I don't think … But, had I met him at a point in his illness where he was more unwell, I might not have discussed so much about my own … life interests and outlook and history and things like that." (Participant 4)

"I've just moved from the (name of town) team to the (name of town) team?...And when I told her she said "oh but you were my only friend"…she was sort of really seeing me in a friendship role…she'd say things at the end of conversations like, "love you" and like you would with a close friends…And it's really hard...'cause I did feel a bit of love for her!...Because it was very sort of maternal relationship….But you really have to…hold back and it's like, try and keep it professional….but caring, and it's a delicate ba- balance with her…it does depend a lot on, on who else is in someone's life…who else they've got…you can turn into that person's only, only source of…deep conversation and….it's inevitable I think that the relationship will develop a little bit like that" (Participant 8)

"*You do get closer to people…some of them just disappear and you never see them again. And you think…didn't we mean anything to you? (laughs)"* (Participant 1)

"*we work more intensely and more personally with people and their families*" (Participant 7)

"I guess EIS work more closely with a client and for a longer period of time" (Participant 5)

"you get to know somebody a lot better" Participant 3

"*it's helpful sometimes, I think, to share perhaps like your hobby, some, some hobbies you might have and maybe you'll have some shared interests that, that would help build that relationship*" (Participant 9)

"*it just seems really weird that after working that closely with someone for three years, suddenly it's like, see you later…I can't contact you again*" (Participant 7)

" *You've got to make them aware you're here three years, but actually what happens when we go...boundaries are important because they need to know how long that…relationship is gonna be there for…and what's going to be there afterwards?"* (Participant 3)

"*sometimes you build alliances with certain people and I think that's where we need to be quite clear all the time and keep on thinking about those, um, yeah those boundaries*" (Participant 3)

"I was er emailing them at seven o'clock just to make sure that they had all the information it's like hang on, you're out of bloody work…or you ring the family at seven o'clock in the evening…That, is a little dodgy" (Participant 13)

"*it depends on what other family you've got around you that you can turn to or friends…sometimes you start thinking…this person's coming to me all the time and that's maybe not an appropriate boundary*." (Participant 6)

"I think [professional boundaries] support me…sometimes you like your client and if you'd met them in different, different circumstances, you might be friends…Sometimes you don't like your client and that wouldn't happen. But you maintain those professional boundaries either way…I think it helps me consolidate that" (Participant 12)

"I guess the other, side of, of things being boundaried is- I can only be responsible for my- for what, for what I do" (Participant 4)

“it's the balance between building rapport and maintaining boundaries that I think is the absolute crux of all of this” (Participant 5)

“*sometimes people struggle to know the difference between…what is a professional relationship and the sort of support that we're offering can be very flexible…it can just blur that boundary a bit too much?...like a friendship kind of boundary*?” (Participant 10)

“*if people have established not very good attachments…and they're looking and seeking for that…they might be looking for that in you, and if you’re somebody that is, the only person in their life that's been able to give them that attention…that’s where I think the trickiness could come in boundaries*” (Participant 3)

“you can always say, like, I really want to give you a hug. Can I give you a hug? You know, you wouldn't sort of just jump on top of someone” (Participant 8)

Negotiating boundaries with families

“*you’re obviously dealing with family members a lot that have a lot of anxiety and um, I think it is important to stay professional with families the whole time. I've always sort of stuck to that because, you need them to know that y-you're not a cowboy*” (Participant 1)

*“The mother was calling me, saying, “I'm gonna chuck her out, I'm not putting up with this appalling behaviour…there's nothing wrong…She's just being awful”…So I disclosed…our service thinks the client’s quite unwell…I went back to the client and I said, “it was me that breached your confidentiality…I'm very sorry…my reason…was because I was worried about you being homeless”…you wanted to reduce harm, but actually you ended up doing it” (*Participant 12)

“*boundaries put in place…to protect…to know who's doing what and it's “well I'm gonna work with him and you work with the brother”…almost to the extent where when one of them is being discussed in MDT one of the other people leave so that they don't hear…although that might be a*

safer way of working…that's just also not reflective of reality in how those families are experiencing their lives together" (Participant 6)

"You know sometimes you just [the client] asked me not to disclose this…but it's really important that you're able to, to still communicate…so you kind of, you can be a bit guided from [the client]" (Participant 11)

Team processes Layer

Sharing decision-making

"*I think we're really good at … discussing that and everyone has their opinions…and you find a middle ground that everyone's comfortable with…I haven't really seen many team discussions where someone's left doing something they're not comfortable with…I can think of one occasion and they actually said, "right, well I still think this is the lesser of all evils, but I'm still not comfortable doing this". And that was really kind of, clear…I think that's really, a healthy way to be working*" (Participant 6)

"*If I'm stuck on something…that can help inform what I'm gonna do next*" (Participant 5)

"I was just going with my colleagues, I guess, to provide support for them as well. Um because the risks are potentially quite different…if you don't know what you're walking into and you haven't heard from someone" (Participant 6)

"if there are real dilemmas in terms of boundary, I think we've got a really good team brain…there's a team culture in early intervention that is helpful in…making these decisions" (Participant 9)

"*I took that to the MDT and said…how close is this? Do you think this is a bit too close?...In the end we did decide as a team that actually…she's not in my kid's year so the likelihood of her coming across my children is pretty slim*" (Participant 10)

"*you'll get ideas from someone else who will say, ooh, the one time we have managed to make it work is when he came in for this or that or the other*" (Participant 6)

"*we'll think about…would it be useful to have a co-worker involved? Not necessarily to actually work face to face with the service-user, but to work with their LP just to…be there for them to bat around (ideas) with*" (Participant 6)

"*if it's a bit more nuanced and a bit more, on the fence, yeah, team discussion is really helpful*" (Participant 9)

"*If I was doing a home visit and something occurs…the first port of call would be, a) internal dialogue on the journey back…2) whoever was in the office…"Can I just bounce this off you?"… if not, then depends what which was coming sooner, um, possibly an email to somebody to say, can I just run something by you…Or supervision or MDT. So, you know what I mean, level and degree of urgency."* (Participant 13)

"*different types of supervision with different…team members…that is a useful one…speaking to the team, team leader or…psychology colleagues can be really good with that [boundary dilemmas*]" (Participant 11)

"you take it to the team and say, "ooh how, how do I manage this?" And everyone will have been through it…they'll say…" why don't we introduce someone else in the team"…or "why don't you have a conversation about it and…make that explicit" (Participant 6)

Individual CM decision-making Layer

Considering motive/rationale

"*if somebody asked me a personal question, my immediate thought wouldn't be to share, it would be why are they asking me this question so it's kind of, I try to explore that before sharing and only share if it's relevant*" (Participant 5)

"it's about the person that we're working with…how does that benefit?. Is that only for our own cathartic use, that we're doing that" (Participant 13)

"*why are they are they asking me, why am I going to share it? Is it relevant*?" (Participant 5)

"*what's driving it…'ve had people say…I've lost three people over the last four years, I'm just shitting myself that someone else is gonna take their life" …another… something along the lines of they "reminded me of an uncle" (*Participant 13)

"*I'd probably deflect it the first time er by kind of, asking why like why that was important. And I'd probably wanna challenge the assumption that it was a boyfriend and not a girlfriend*" (Participant 6)

"*Every time they went to visit…the person would buy mint club biscuits for when they arrived…cause the client knew that that was the practitioner's favourite…you think…that seems okay…Until one day the partner came in and said "oh I'm glad you can afford to buy club biscuits when…we haven't got any dinner for tonight*"" (Participant 12)

Incorporating moral/ethical values

"*if your colleague said 'oh God I haven't got any food in the cupboard'…if one of your co-students said, 'I've got nothing in my cupboard', you'd give them a fiver if you had it*" (Participant 12)

"*I think ethically, it's a good thing to do…it's like your moral compass and your ethical compass is like…going that way*" (Participant 13)

"*that is…breaking a boundary…On the other hand…morally, would you honestly see…somebody go without food for the sake of a fiver*?" (Participant 12)

"*I was working with someone that…had serious immigration issues…the more you looked into it you realized…he'd been dealt a complete injustice and shouldn't have been in prison in the first place and should have been in hospital?...this was…causing him a lot of stress…Lost his visa, because he'd been to prison…But he'd been to prison because he was psychotic but just wasn't picked up…with people*

like him…I think…there's like a moral duty to actually do something about it rather than just leave it…And he would end up getting deported" (Participant 1)

"suddenly you can be like ooh…am I being too involved or am I now doing, you know kind of even between professional boundaries am I now doing…what…carer support should be doing or what the doctor should be doing" (Participant 6)

"*I guess something about my own personal morals and, rules for living and that kind of thing*" (Participant 12)

"*that's a really key thing to…what this job is…it's unrealistic to expect that people will not be themselves to some extent in their work*" (Participant 11)

Drawing personal boundaries

"in my argument in my own head it's like, yes I can understand why and how and I've probably done it a little bit more, but within my own internal boundary, of saying "yes I might have had some sort of like lived experience" …But that's as far as it goes. So you know what I mean there's the boundary within the boundary" (Participant 13)

"*I find working with female clients…more challenging…because when I was younger I went out with a girl who had bipolar disorder…I find, acutely unwell young women quite, quite upsetting…Because of that relationship…And that was a very intense relationship*" (Participant 4)

"*I've…got a Christian faith…whilst I…support people if they…mentioned something about their spiritual faith…he kind of said…" have you have you got a faith?" ...I just said…" that's not something I would share…we're here about you" …it's my, my boundary*" (Participant 10)

"*What I don't share would be something more like where I live…maybe personal things about my family*" (Participant 5)

"*I wouldn't share things like…my date of birth or birthday…I…give a quite vague answer?...I'm a winter, a winter baby*" (Participant 10)

"*I've…always kept off the electoral register so people can't look me up on there or that information can't be found*" (Participant 10)

"*I thought…I don't want to tell you my child's name*" (Participant 2)

"*I don't tend to work with many female clients… if someone is really quite vulnerable…sexually…I don't think it would be appropriate for them to be working with…a male necessarily…it's something that I don't personally feel particularly comfortable with*" (Participant 4)

"*if someone's got…the same GP as me…I won't work with them…because I don't wanna be sat, in a GP surgery about my own personal things and somebody sat there next to me that I know*" (Participant 10)

Using self-disclosure judiciously

"*I might say "yeah, I've got children" …but not give details of their age, sex, school, you know, or anything like that*" (Participant 12)

"*it's always somewhat of a gamble because you don't really know people that well or you don't know what kind of things might, might be an issue for them in the past, that, that may come up later and it might be, it might be more difficult for them when you have to disengage if you've shared this, this stuff with them on a more personal level"* (Participant 7)

"*having chats about…what you've been doing in your spare time…because you're sitting in a car…you're not necessarily gonna have a kind of in depth conversation about what you normally would have in a meeting…but, you can't just sit in the car in silence…You end up having these…I might have had a chat about…things I might do like going for a run…or…they'll say "oh did you go out"…you end up saying those things and thinking…did I really want to give that much information away…But…actually that's been helpful to that person*" (Participant 3)

"I probably share more than the majority of people do?...I quite often have talked to people about my family or…things like that. I don't share any intimate details but I might say…I've been up all night because of the baby…I've had clients I'm working with who have taken an interest and said, "Oh, how, how are you getting on with the family" and "how's the baby getting on" and stuff like that and, generally I've felt quite comfortable with that, and that's not be an issue…I'm asking them about their kids, um, and their life and their relationships…And, to share it in quite, intimate detail…if I'm not prepared to be a, be a human as well who has similar experiences, then like you say, why, it just feels a bit disingenuous" (Participant 7)

"*you pick and choose…what you share…because, mostly…I'm sharing for a purpose…Because I feel that there's a benefit in doing that*" (Participant 10)

"*if you are trying to encourage that person to go and do some physical exercise…then you say, "well I did go for a run at the weekend" and they say, "oh, how did that go?", and I say…"it was good, but…I haven't been for…you sort of explain…your motivation and stuff and, they get a bit of insight…I think it does help people cause it helps normalize""*" (Participant 3)

"*sometimes it helps…to know that you, you're not this nurse coming into their life as a saviour and your life is perfect…it helps to kind of share that you aren't this perfect person coming into their life and, you know…help them with being more honest with you in a way? knowing a bit more about what you're really like"* (Participant 8)

"*I might give an example like, if I say to my children "tidy up your room, pick all those clothes up" (pretend shouting) they're likely to completely ignore me…But if I say…'are you guys going to get round to sort of tidying this bedroom up a bit?', and…'do you want to bring your washing down?'…They're probably gonna respond to that. So I might use that kind of example*" (Participant 12)

"I might share that I have a child, that I'm a mum…that will only really be probably if I'm talking to somebody in a similar situation because…that's more likely to come up where they ask me that question that seems quite important to people in, when they want to hear that I might understand what they're coming from" (Participant 5)

"*I have a physical health, difficulty?...a physical diagnosis…That impacts my day-to-day functioning and I might share that in the right kind of context…if they, again have a similar kind of experience…maybe as a bonding thing but also as a, understanding of an impact on someone's lif*e" (Participant 5)

"If you…start talking too much about…your own personal life or, or experiences…that can kind of be intrusive to the person, using you as a therapeutic kind of object?...they need to…interpret you…in a way that…is helpful for them not…and sometimes like bringing in your own reality can be really intrusive and unhelpful" (Participant 11)

"*if you come across as having a very…comfortable perfect little family…home life it could…create a bit of imbalance in the relationship…If they haven't*" (Participant 8)

"i*t's not the client's job to listen to my difficulties*" (Participant 12)

"*This isn't about me, it's about them*" (Participant 13)

"Other people are completely oblivious to it and I'm like, ahhh, I think we should... I might…try and like keep the conversation…keep it discreet, so I'm always thinking about yeah who's around at this time and who's, who's listening in on this…it's none of their business… it's sort of, keeping that there" (Participant 11)

"if you're saying something that could feed into a delusional belief system, if you're feeding something…which…. could become an overvalued idea" (Participant 4)

"the step dad said to me…have you ever used drugs?...I said um, sort of with an element of humour "well, I couldn't possibly discuss that because um, professional boundaries and everything!...I've

taken recreational drugs in the past…I don't think I've ever explicitly said that to a client and I don't think that would be appropriate to do so" (Participant 4)

"*if you were one of my clients and you said to me "where do you live?" and I said, "I can't tell you that" …"I'm not required to share that information with you" or…even, "we don't share that "…I don't know there's something about a barrier being formed"* (Participant 12)

"*So, I think it's thinking about what you can say in a measured, and, professional way…Without over disclosure*" (Participant 12)

"I'm just very aware of our influence, or potential influence on people…At a vulnerable time in their lives…if it was relevant to that person I would explore something from their perspective with them" (Participant 10)

"*I still need to come up with that answer for where I live…So that I feel comfortable…when I do get taken a bit aback*" (Participant 10)

"*Most of the other ones…like what's your date of birth…you can kind of play it off a little bit*" (Participant 10)

"*you're talking to somebody who's…describing something that's happened to them and they say…nobody understands, no-nobody knows what I'm going through and I'm thinking, pretty much the same thing has happened to me…it might be a life event that…I can relate to…I'm sort of biting my tongue 'cause I think…I can totally relate to what you're saying here…but… it feels as though that would be…undermining perhaps their….experience of it…So I, I tend to hold back in that situation and just…validate what…they're feeling…at that time rather than saying well…I could guess how you're feeling cause I've, I've been through the same thing. It just feels as though that's…taking away from their…experience"* (Participant 9)

"it was like…you wouldn't know because you wouldn't have no mental health issues yourself" …it's like "well, lots of staff, including myself, do have lived experience" but that's as far as I went but…I kind of, without sounding too crass used that as almost as a tool" (Participant 13)

"*if you gave him a date, he would, he'd never forget it so I…made a bit of a joke of it, kind of saying…" it's not you know, it's not polite to ask a lady's age" and all this"* (Participant 10)

"*I'd probably deflect it the first time…by kind of, asking why like why that was important And I'd probably wanna challenge the assumption that it was a boyfriend and not a girlfriend"* (Participant 6)

"*If I'm going to share I've got a daughter then it's gonna be easier for me, a parent to maybe bond or the…working relationship might be easier if they feel I have common ground…then…I might not have to work as hard on…engagement in other areas but that's not always useful- that's not necessarily useful for them that I've got it easier in that moment*" (Participant 5)

"I think that could have come across like, yeah I'm asking you to tell me all of this information about you yet I'm not willing to tell you anything (Participant 2)

"I think the general rule of thumb is…is it helpful for them to know that?...is it potentially unhelpful for them to know that?" (Participant 11)

"*as clinicians we think…we need to be boundaried in this relationship…not give away too much about ourself, but we're expecting a lot back from them. We, we expect to know the ins and outs of their dietary intake, their bowel movements…Trauma, relationship difficulties, drug use*" (Participant 9)

"*there is some level of self-disclosure…To try and build a rapport with somebody*" (Participant 9)

"*there's ways of er, gaining rapport, which I've certainly used about talking about films or music and things like that. But they're quite neutral?"* (Participant 13)

"*they might say "well I have this issue with my child" …I won't typically say, that I have the same problem but I might say "oh I understand how you feel…I can…completely relate*" (Participant 3)

Making decisions on a case-by-case basis

"she rang me and said, I can't go [into respite] because…my dressing gown's not clean…I haven't got any clean pyjamas…my washing machine and tumble dryer aren't working…this was…late afternoon before she was due to go in the next day…I said to her, this is a one off, because…I think it's really important that you're able to go in…so I did…one load of washing…Put it through the tumble dryer and delivered it back to her…she was so unwell and her family was so burnt out…So, I weighed it up and I broke this boundary…told the team leader…I said, "but you know my rationale was, she desperately does need this respite"…It was difficult for me to find somewhere else that I could do this laundry in work time in a work environment…I was acutely aware that I had broken a boundary but…it worked." (Participant 12)

we're not able to say a, a specific like, clear and fast rule for every single possible boundary that you could, could meet" (Participant 11)

"*I probably take more of a…directive approach with him in a way…it is a different sort of…relationship…And that's what seems to work…with him*" (Participant 10)

"*if someone is on my caseload and I know that they have particular risks...I'm a lot more cautious…saying things about whether or not I have a partner…whether or not I have children…it is different and it's usually around risk, sadly…and unfortunately risk changes, so I haven't had cause to have significant regret around that yet, but that is something that…does sometimes cross my mind*." (Participant 4)

"*working with younger people I tend to be more boundaried?...put that in place right from the very beginning… if need be, you can relax it as you get to know them slightly… whereas…with…older clients, at times you can be a bit more relaxed from the beginning*?" (Participant 2)

" I very much gauge it on how the individual is towards me maybe on first or second contact…Sometimes, it's appropriate to be more explicit" (Participant 13)

"there's always gonna be a, no matter probably how experienced I am there's always, there's always a bit of an unknown that, am I being strict enough and or am I being structured enough with this person, because you never really know…You don't know them well enough to know, a hundred percent, this is the right approach" (Participant 7)

Using Instinct/clinical judgement

"it is just something that isn't really, there's no training…it's not really spoken about very much it's just something you pick up on the way" (Participant 2)

"*the sort of…non-scientific gut instinct of what's right and what's wrong…an instinctual feeling…. probably based on experience of when…something feels uncomfortable*" (Participant 12)

"*If something doesn't feel quite right, then it probably isn't…then I guess one has to think about…even if it's not quite right, does it still need to happen, and what would be the consequences?"* (Participant 12).

"*it can be, more stressful…knowing that you may be making the wrong call…you've always got to have that in the back of your mind that…you've probably assessed the situation correctly and this is an appropriate level of personal, you know, relationship*" (Participant 7)

"*That tacit knowledge of…what's been helpful in…previous experiences…what the value is in…maybe pushing the boundaries a bit…Versus the, the risk of pushing the boundaries*." (Participant 9)

"*the other thing…that has improved…with experience is, knowing about these grey areas…recognizing these grey areas, knowing what to do about them…confidence in one's own sort of professionalism…and being able to reflect*" (Participant 12)

"it's sort of practice, personal experience…I'll draw on experiences I have that are similar, as well as seeking support and supervision" (Participant 5)

"I helped a client…apply for PIP…he was successful and it was backdated…And he bought me the most humongous, beautiful bunch of flowers…And it must have cost him about fifty, sixty quid…And I

said to him, "I can't take that"… And he said, "you…you have to…you know you've supported me. I want you to have it."…I was like "I really can't" and he's like…I'm not hearing this"…And this went on…In the in the end…I took the bunch of flowers…to maintain my therapeutic relationship with a very difficult to engage client…he was not having no….And he would have been quite offended…So what I did, to…get over my dilemma, was I took the flowers to (name of local mental health unit)…And handed them in, to be on reception…and I documented that I've done it…And I took it to the team meeting…And a couple of weeks later when I saw him, I said, you know, "me and some of my colleagues really enjoyed your flowers"…To dilute the, 'they're for me', do you know what I mean?" (Participant 12)

"some things are clear cut…But the washing example is less clear cut" (Participant 12)

"if I told somebody from a risk assessment… "what you used somebody else's bike and you didn't have a helmet and you didn't have a"… all the sort of things that I can say like I'm, I'm managing my own health and safety are not there, but…I know as a person I'm confident…riding a bike, I'm confident that I can separate, if I fell off that bike or something happened ,that I would just deal with it" (Participant 11)

"he bought me the most humongous, beautiful bunch of flowers…it must have cost him about…sixty quid…to maintain my therapeutic relationship with a very difficult to engage client…I took the flowers to (name of local mental health unit) …to be on reception…a couple of weeks later when I saw him, I said… "me and some of my colleagues really enjoyed your flowers" … To dilute the, 'they're for me'" (Participant 12)

Employing flexibility

"*we kind of just fit in with wherever that person is in their lives and, just try and fit in I guess in the least obtrusive way*" (Participant 6)

"*Because, it's so vague you know, you don't know and then you come in on, you know, Monday morning or whatever and you open up your phone and then suddenly you've got a text and you're like, I don't know when that was sent and…that's a kind of, the real issue with it that I think needs, needs watching… that's one I'm learning about over time…remember to tell people like, do not text if anything's urgent, if anything's important, do not text"* (Participant 11)

"*we'll try to be very flexible because some of the people we're…working with…they're not necessarily coming to us saying I want help*" (Participant 10)

"I think it's just, perhaps, yeah, being a little bit more creative, um, with sometimes with like the settings and the and the way, that I engage people but, yeah I think I'm still very much…aware of the professional boundaries" (Participant 2).

"*the boundaries around timing – there needs to be flexibility, because we're encouraging people to get back to work…then saying well, you can't see us or talk to us because…we both finish at five…I've sat in car parks with people in their lunch break or, sometimes I do a meeting after five, you know, family therapy after five…but I don't see that as breaking a boundary because…there's transparency there…you're telling the team; you're buddying up, we're saying we don't usually do this but, to support you with work…that is possible*" (Participant 12)

"i*f you see your team leader…engaging in that discussion and, and being open to people's opinions about it then you realize that…things aren't black and white and that we can play with that a little bit within our individual boundaries….it just feels a lot more honest, I think, than having a black and white boundary, because that's just not how anything ever happens*" (Participant 6)

"sometimes you might find that you've actually maybe become, you know, that person views you as, you know you want someone to trust you and to be able to come to you when it's appropriate. But obviously, of the definition of what's appropriate is so... vast and that's going to depend whether you're in the middle of a psychotic episode or whether you're just ticking along well." (Participant 6)

“the definition of what's appropriate is so..vast and that's going to depend whether you’re in the middle of a psychotic episode or whether you're just ticking along well.” (Participant 6)

“*you’re trying to minimize that power dynamic as much as you can which means being more flexible with the boundaries*” (Participant 6)

“one of his goals really is to gain weight. He's quite underweight? *So we started going to sort of cafes and get-getting a bite to eat. And then, sort of more recently he said, ah well could we not, you know, I might get a beer, might get a few beers in. Um, and I’m sort of thinking well, you know, ideally it's, it's not, it wouldn't, ideally you wouldn't be drinking alcohol when we're meeting up because it feels like perhaps that's overstepping some sort of boundary (Mhmm mhmm) Some unwritten boundary about, you know… but then equally it's his life you know, and if he wants to get a beer, why not? So it's sort of and if that's, if that's meaningful to him and he you know, that's his only social interaction with somebody and he wants to get a beer, then it's not really my, is it my place to be saying, whoa whoa, you know, boundaries mate, you mean, we, you shouldn't be drinking alcohol when you're meeting up with me as a professional, you know…this person's…living out in the community…they're able to make those decisions…they've got that capacity…I think what I said was, um, ideally it'd be nice to catch up with a clear head, (laughs) but it's up to you, I'll leave, I’ll leave that decision up to you. And he said, “oh go on I'll just have a half then”* (Participant 9)

“Yeah, that's a common thing- getting texts on my phone, making sure I don't, sometimes I might turn my phone on to check my calendar, to see what I'm doing the next day? (Mhmm) And then, you get texts at night regularly (Yeah) Sometimes it's just cause they’re text- that's when they remember to do it and they're not expecting you to read it until 9 o’clock the next day but sometimes it could be what shall I do now? And once you've seen it (yeah) you’ve seen it” (Participant 7)

“*it can be, more stressful…knowing that you may be making the wrong call because there isn‘t a very rigid structure about boundaries that there would be in CMHT…Where, everybody calls duty. You see them once a week, max…they come to the team base…Whereas we might text somebody say “do you*

wanna meet me at the gym, do you wanna go to the gym together?"…So you've always got to have that in the back of your mind that…you've probably assessed the situation correctly and this is an appropriate level of personal…relationship" (Participant 7)

"*there's some flexibility in boundary setting…Provided…we bring in the code of conduct…And the… um personal boundary…it's a quite a complex… picture, isn't it?... and the instinctual stuff…it all kind of combines, and you know… is processed"* (Participant 12)

"*it can be quite refreshing when a practitioner relaxes the boundaries enough to be quite creative in engaging somebody*" (Participant 2)

"it's based on circumstances…what I'm faced with professionally, and how I can overcome them. So, for example I wouldn't be offering to do everybody's washing…unique scenarios call for unique thinking" (Participant 12)

"*that's why we have to be a little bit more flexible…I might go for a walk with somebody and I might be doing the same work, but if I sat in a clinic room you would never…be able to work successfully in in that way*" (Participant 10)

"there's some flexibility in boundary setting" (Participant 12)

Transparency

"*the big thing really is being open, honest and transparent…it is very much a kind of like just laying out very clearly, and you know, sensitively as well*" (Participant 13)

"That clearly indicates to me that I've broken a boundary, if I'm not able to be completely transparent with the whole team, a boundary has been broken" (Participant 12)

"*you're being so transparent so there's no risk…you mentioned at the beginning of the interview…if you disclose something that's, a really inappropriate boundary breach…we'd have to report that and I remember I kind of thought, well that just couldn't happen because we…check in so often about*

how we're working with people…No one's kind of holding secretly to well this is what I do with my patient… it's just super open and transparent" (Participant 6)

Individual prior influences

Innate stance

"if you come from the wards that I've worked on it was very sort of huggy and…you're dealing with personal care and like literally people are naked in front of you…It's like, just wade straight in there sort of at the deep end…I think when you come from that background as your first job after qualifying you automatically kind of, there's not much there in between" (Participant 8)

"I'm quite a reserved person and I don't ordinarily like to divulge too much personal information" (Participant 2)

"I think it's probably rare that I'm too strict" (Participant 7)

"there are colleagues who I think who are much more boundaried" (Participant 5)

"I probably haven't changed that much?...I started off…fairly relaxed about it…And I still am" (Participant 8)

"I always go on the safe side, you know" (Participant 1)

"maybe I'm a bit too boundaried, I dunno. Also I guess it gets reinforced sometimes so like, "oh we'll get (name of participant) to go and do that because he'll just, he'll just do it and then, leave again"?...sometimes I think like, yeah I will but then, does that mean that I'm actually…I shouldn't be like that?" (Participant 1)

"I'm possibly a little bit blasé to begin with? And I need to start off at a more boundaried point and gradually loosen them as appropriate rather than starting from a place where there aren't really any boundaries and then putting them in?" (Participant 7)

"it's also about the type of people who go for this job, so I know, in my previous team there was somebody there who kind of who was very like rigid said I would never tell anyone that I even had children or not, whether I, anything about myself at all…always saw people at clinic, never went out on home visits, was, and was just very, very boundaried and I kind of felt a bit like oh gosh I do share a little bit…About myself…and I guess this kind of work maybe attracts people who, who are more likely to work a little bit more flexibly and therefore, be a bit more willing to have more flexible boundaries" (Participant 10)

"in my previous role it was just the same … So, for me, you know often I'd meet where, you know, you know… to engage some of those forensic clients, you often have to think outside the box … And you know they were… you know they had difficult interpersonal …(relationships) Um you know difficulties with interpersonal stuff … Interpersonal communication. So you, just like in EIS you think outside the box to engage a young psychotic person … So, we had to think, you know, I had to think outside the box with the forensic clients, you know, they were equally different, difficult to engage, potentially, as, you know, as each other" (Participant 12)

"*my background before this was working in a prison and…there's a lot of stuff about boundaries and..prisoners trying to condition you and, um you being aware of being drawn into things without you really knowing about it…I think that's being driven into me from that kind of job, so I've always been a bit, um keep them at arm's length"* (Participant 1)

"I'm reasonably boundaried…I don't think anyone would ever describe me as an unboundaried practitioner…I'm relatively strict…but then I will share information…I'm not completely, completely one way or the other" (Participant 5)

"when you think back to the wards…very boundaried…you don't give anything away… I don't necessarily like being that boundaried?" (participant 2)

"*I've then been in early intervention services for most of, my career…I wonder if I'd stayed in children's services where things did feel more unsafe…I maybe I would've stuck more towards the very boundaried, unsharing a position I held before*" (Participant 5)

Training experiences

"*the professional bodies…when we're newly training, tell us what we can and can't do which… sets the stage for, you know, your initial work when you're newly qualified*" (Participant 12)

"that was…twenty-eight years ago that I heard that and it's never left me…in terms of kind of, protecting people…this is your duty of care…to live by the code, die by the code" (Participant 13)

"*One of my first placements…I remember this social worker telling me things like, when you go there to park, make sure you turn your car around so if you have to exit quickly…you're able to get in the car and get away. Those kind of conversations happened really early on…So I think my safety as a practitioner affected my thinking about boundaries really early on…On my training it was certainly about safety and It was-quite a fear-provoking conversation though…when you're a new trainee" (*Participant 5)

"*when you're in that stage and you haven't been through training, you haven't necessarily thought about it in a formal way, so it was often…nurses coming in and saying, oh, you know, you need to watch your boundaries, this person is getting too attached*" (Participant 2)

"so much of my…nursing training has sadly been about…preparing for coroner's court?...if you don't write it down, it didn't happen. What would happen if this case went to Coroners Court-there's such an emphasis on kind of not losing your pin…it's much easier to have a clear black and white boundary" (Participant 6)

"*On our course…they did a PowerPoint presentation and there was a picture of somebody on Facebook you know, flat out drunk being carried out by the bouncer and it made it to the local newspaper…and shock horror she was a nursing student…and that's it, she was no longer a university*

student…they were like…how you present yourself on social media you know Facebook or Twitter…I find that world quite difficult to deal with anyway so I tend to avoid it I don't have Twitter and Instagram…but I just remember finding that, that that was just a really uncomfortable idea" (Participant 6)

Shaping Moments

"there are cases that come into mind…where they felt, the service user's felt like the boundaries were really crossed…I found that very thought provoking" (Participant 9)

"When I first started nursing years ago, and it's really stuck in my mind, we had a lecturer…one of his first speeches was about power…he said, in this profession, and this was general nursing, what other professional can you say to a strange person, "take all your clothes off, lay down on that trolley and I'm going to stick something in you". And then after that, they'll say "thank you very much" …to me, that sums it up … um, in terms of power, that's what we've got" (Participant 13)

"I had such a baptism of fire in this house when I was 21 years old…I had to think about my boundaries every day…it was such a formative experience for me" (Participant 4)

"I got a house about two roads away from the hostel, and then I told the manager when I got the job, I said, "oh I only live down the road oh it'll be a two-minute walk" and, and he was just like "Oh you've made a big mistake there" (Participant 1)

"I know people that have gone to prison for taking drugs in for, inmates, you know" (Participant 1)

"in the real worst circumstances things do happen to people and when you hear those stories, those are the ones you remember" (Participant 1)

"you remember these sort of incidents, you know, that you get told about…I can't believe that happened, you know…that sort of stuff is always in the back of my mind, really" (Participant 1)

"I had to deal with a…boundary issue where a healthcare assistant started a relationship, with…someone that used the service, although they weren't currently in the service…they actually started a relationship and that, that was a real eye opener" (Participant 13)

"I worked somewhere in a house with a group of people with learning difficulties and there was a woman there who was a nurse who had practically adopted one of the residents…almost like a pet or something, and I thought oh my God this this doesn't, this doesn't seem appropriate" (Participant 4)

"*I was working in brain injury?...they can be quite disinhibited and not really…understand boundaries so much…I had someone who was really over familiar…thinking of you as being a friend…not really understanding that different relationship?...I had to explain, I had to really lay down the line and explicitly explain what, you know how our relationship as professionals is different to um to a friendship. I think having that in your mind I think sets that kind of, kind of bar and you'll have that in your mind, you know, in, in future kind of situations*" (Participant 3)

Learning/calibrating cycle

Gaining clinical experience and tacit knowledge

"I'm learning how I'm developing those boundaries myself" (Participant 6)

"That's, that's a, and that's one I'm learning about over time, you know, to to to remember to tell people like, do not text if anything's urgent, if anything's important, do not text" (Participant 11)

"We don't have a guidebook … In EIS you just get into this job and it's kind of, obviously we do have some kind of idea … Um, it er I think we kind we kind of have to make our own way in a way? … Find our own feet? And react to different situations? (Participant 3)

"growing in confidence I would say …As time goes on, and knowing what, what's been helpful for sort of that tacit knowledge of what's, what's been, what's been helpful in, in previous experiences what, you know, the, the value, what the value is in, in, in maybe pushing the boundaries a bit …Versus the, the risk of pushing the boundaries. Um, yeah, it's growing in confidence" (Participant 9)

"Because I think it is just something that isn't really, there's no training, there's no, it's not really spoken about very much it's just something you pick up on the way" (Participant 2)

Constant comparative process / "calibrating" boundary compass

"maybe I'm a bit too boundaried, I dunno. Also I guess it gets reinforced sometimes so like, "oh we'll get (name of participant) to go and do that because he'll just, he'll just do it and then, leave again"?...sometimes I think like, yeah I will but then, does that mean that I'm actually…I shouldn't be like that?" (Participant 1)

So I think, yeah I think I'm always sort of thinking, oh, would someone else have done it like this?" (Participant 3)

"I think a lot of times you do have a bit of a leaning but you just need that confirmation or affirmation … Er and I think ethically, it's a good thing to do … 'Cause it's like your moral compass and your ethical compass is like, well I think it's kind of going that way, and, oh yeah so what I was thinking was on the right lines and I'm not going off at a tangent" (Participant 13)

"I I like to know other people's opinions. If I'm stuck on something, um yeah that can help inform what I'm gonna do next" (Participant 5)

"if there was something I wasn't sure about with boundaries, um, I'd and I'd like to think that um, you know, I'm quite open with what I'm doing with people … So I'd think that someone would pull me up on it as well, if um, there was something that they didn't think was right, because I'd, I'd um, I'd wanna know for my own kind of sanity, you know?" (Participant 1)

"I, probably have usually got my er er thought about what I think is appropriate or not…I'm probably, I'm probably already leaning one way or another … Um, so in a way you're just you're getting other professional opinions about whether, you're, the decision-making process is, is, is okay and it's kind of about, yeah, so weighing up risks really, I guess? … Weighing up kind of, you know, risk and benefits as well?" (Participant 10)

"I'd probably seek out people, that I felt had sss, and this sounds slightly contradictory, but had similar professional… boundaries and ideals as me … Cause some people, if I went to some people, and said, you know would you ever say that you lived in the (name of town) area, they would say" absolutely not"…You know, "I would not say any geographical location"…So I would probably go to people, who I think have good boundaries … But equally, you know have a good sense of how to therapeutically engage … Have a good level of experience …Um, and I guess are worth me going over it with … That sounds awful doesn't it …But yeah … no and You know, If I don't respect them professionally, I wouldn't ask their opinion" (Participant 12)

Reflecting on practice

"when you don't get someone to engage with you it can feel, that can be, you know, that's a great learning point and it's an opportunity to learn" (Participant 6)

"it's recognizing these grey areas, knowing what to do about them…and being able to reflect, you know, reflective working, you know, self-reflection" (Participant 12)

I think um, potentially, the use of like reflective practice…we have that every fortnight and it's a really good opportunity especially at the moment where we're not meeting very often as a team, um, you know apart from zoning" (Participant 2)

"we're starting to do like a, bit of a fish bowl exercise?...Within reflective practice so that could be one of the topics that we discuss" (Participant 2)

"If I was doing a home visit and something occurs, and I came back to the office the first port of call would be, a) internal dialogue on the journey back … In me head … (Participant 13)

"having a reflective practice…more of that maybe would be helpful with the team…. depending on what situations they've been in or any difficult, I don't I don't know having it as a group, a team thing would be helpful" (Participant 3)

"what often happens with that is that we'll offer…would it be useful to have a co-worker involved? Not necessarily to actually work face to face with the service user, but to work with their LP just to, to be there for them to bat around [thoughts] with" (Participant 6)

Learning from others

"probably, er from being qualified been I I I worked in a very experienced team from a very young age … And I followed the the other, other t-professional's lead in how to work in the community" (Participant 10)

"I think it's really helpful in our team having the peer workers, and sort of drawing on them, and sort of, saying you know, if if this were to, if, if I were to sort of, chall-push this boundary a bit, can you, do you have any thoughts on how that might impact the, the patient or the family?" (Participant 9)

"yeah I think I've seen lots of good examples of role modelling … um in my career, is a fair thing to say" (Participant 5)

"I think it helps, helps being around people that have been qualified … a long time … Um, when I was newly qualified, 'cause that was a help, their experience I think definitely did rub off a bit" (Participant 1)

"general conversation with, with other clinicians and …Um, "what do you reckon you, what what do you make of this?" or what "How might you approach this?"" (Participant 9)

Using supervision

"If I was doing a home visit and something occurs, and I came back to the office the first port of call would be, a) internal dialogue on the journey back … In me head … 2) whoever was in the office … "Can I just bounce this off you?" Then, if not, then depends what which was coming sooner, um,

possibly an email to somebody to say, can I just run something by you …Or supervision or MDT. So, you know what I mean, level and degree of urgency." (Participant 13)

"I think it's, it's not a bad thing to have… a bit of a chat and a, a reinforcement about, even if it is a bit kind of like, yeah, I've disclosed about this or I've disclosed about that. Yeah, but again it's that thing of like" okay well did that help?" … Was that, that, what did that actually bring up for you? … Maybe because again it's back to what is, what's driving it" (Participant 13)

"a lot of the times I would, kind of in my or have a chat with the practitioner of like, what is it you're worried about? … Er, you know if they-we, if we do, pull back, what is it, that's the worst thing that's gonna happen sort of thing … You know what I mean, w-and then find out for them and sometimes that can be quite illuminating in itself" (Participant 13)

"I think so I mean, generally, I think our team supervision is really helpful. Um, I think even informal kind of conversations with other clinicians in the office …I know it's less, that's less possible at the moment. But, yeah, general, general conversation with, with other clinicians and …Um, "what do you reckon you, what what do you make of this?" or what "How might you approach this?"" (Participant 9)

"think different types of supervision with different um team members you know…. that is a useful one, I think, you know, speaking to the team, team leader or, um, er, yeah I guess psychology colleagues can be really good with that" (Participant 11)

"probably talking with supervisor or team leader or supervisor probably. I guess just to talk it through about your concern, that, yeah, I think, thinking through sort of how you can do, go about it a bit differently" (Participant 3)

"in terms of where that professional relationship is, and how someone feels about it … I think could be expanded on and… not as … doesn't mean to sound as it probably as it comes out, not as a reminder like a rap on the knuckles but a kind of, how are you with the boundaries, you know, do you

think you're doing alright with them or where you're at with them I think, probably doesn't get discussed… in a more of a supervision thing … Where it probably it does, need to be" (Participant 13)

Finding a balance

"*one of his goals really is to gain weight. He's quite underweight? So we started going to sort of cafes and get-getting a bite to eat. And then, sort of more recently he said, ah well could we not, you know, I might get a beer, might get a few beers in. Um, and I'm sort of thinking well, you know, ideally it's, it's not, it wouldn't, ideally you wouldn't be drinking alcohol when we're meeting up because it feels like perhaps that's overstepping some sort of boundary (Mhmm mhmm) Some unwritten boundary about, you know… but then equally it's his life you know, and if he wants to get a beer, why not? So it's sort of and if that's, if that's meaningful to him and he you know, that's his only social interaction with somebody and he wants to get a beer, then it's not really my, is it my place to be saying, whoa whoa, you know, boundaries mate, you mean, we, you shouldn't be drinking alcohol when you're meeting up with me as a professional, you know…this person's…living out in the community…they're able to make those decisions…they've got that capacity…I think what I said was, um, ideally it'd be nice to catch up with a clear head, (laughs) but it's up to you, I'll leave, I'll leave that decision up to you. And he said, "oh go on I'll just have a half then" (Participant 9)*

"meeting different people with different ways of, of negotiating it 'cause it, it's all it's just this kind of, like constantly moving thing and it's, it's a negotiation'. It's a very live active thing of like how do you negotiate the boundary…how do you negotiate the, the relationship" (Participant 11)

"you really have to…hold back and it's like, try and keep it professional…but caring, and it's a delicate ba- balance…it does depend a lot on, on who else is in someone's life doesn't it? who else they've got…you can turn into that person's only, only source of sort of, er deep conversation and, yeah, and it's inevitable I think that the relationship will develop a little bit like that" (Participant 8)

“I helped a client…apply for PIP…he was successful and it was backdated…And he bought me the most humongous, beautiful bunch of flowers…And it must have cost him about fifty, sixty quid…And I said to him, “I can't take that”…And he said, “you…you have to…you know you've supported me. I want you to have it.”…I was like “I really can't” and he’s like…I'm not hearing this”…And this went on…In the in the end…I took the bunch of flowers…to maintain my therapeutic relationship with a very difficult to engage client…he was not having no….And he would have been quite offended…So what I did, to…get over my dilemma, was I took the flowers to (name of local mental health unit)…And handed them in, to be on reception…and I documented that I've done it…And I took it to the team meeting…And a couple of weeks later when I saw him, I said, you know, “me and some of my colleagues really enjoyed your flowers”…To dilute the, ‘they’re for me’, do you know what I mean?” (Participant 12)

“she rang me and said, I can't go [into respite] because…my dressing gown’s not clean…I haven't got any clean pyjamas…my washing machine and tumble dryer aren't working…this was…late afternoon before she was due to go in the next day…I said to her, this is a one off, because…I think it's really important that you're able to go in…so I did…one load of washing…Put it through the tumble dryer and delivered it back to her…she was so unwell and her family was so burnt out…So, I weighed it up and I broke this boundary…told the team leader…I said, “but you know my rationale was, she desperately does need this respite”…It was difficult for me to find somewhere else that I could do this laundry in work time in a work environment…I was acutely aware that I had broken a boundary but…it worked.” (Participant 12)

“I saw this client yesterday…he's been really keen to go for a bike ride….And, I brought my bike last time and we went for a bike ride and that was fine….this time…I couldn't bring my bike…And I turned up there and then he was like “well, you could borrow my parent’s bike” And I was like (laughs) errrrr, this is weird with boundaries and covid…he was so keen to go, and I just thought well actually what's the harm, he was like “my parents said you could use it”….if I told somebody from a risk

assessment, I hope this doesn't go to them…"what you used somebody else's bike and you didn't have a helmet and you didn't have a"…all the sort of things that I can say…I'm managing my own health and safety are not there, but…I know as a person I'm confident…riding a bike, I'm confident that I can separate, if I fell off that bike or something happened ,that I would just deal with it…Whatever "worst case scenario" was in terms of risk, I would be able to manage it and deal with it without it being a calamity…I was weighing that up against…the disappointment of this person…he'd been texting me and calling me saying "are you gonna bring your bike, are you gonna bring your bike"…It was obviously really, really important to him…and I enjoy a bike ride as well myself. So…I just weighed up the…potential harms and how they might be managed and the potential…impact on him…and I'll discuss it in supervision, but maybe that boundary was a little bit…You know, not, not appropriate, it might be more appropriate to say "well let's do it another time you know, let's go for a walk today", um, but…those are the sort of difficulty dilemmas you're facing" (Participant 11)

"*it's thinking about what you can say in a measured, and, professional way…Without over disclosure*" (Participant 12)

"*as clinicians we think…we need to be boundaried in this relationship…not give away too much about ourself, but we're expecting a lot back from them. We, we expect to know the ins and outs of their dietary intake, their bowel movements…Trauma, relationship difficulties, drug use*" (Participant 9)

"*I might say "oh I understand how you feel, you know, I can-can completely relate to that" but I never ever go into details…but at least they can see that we're human?…we're not just robots and that we don't just sit here and go, "oh, okay" you know*" (Participant 3)

"with that young person, it started off with let's go to McDonalds and I used to buy him out of our petty cash a, a milkshake…That's what he wanted and then from there it it was okay can you buy me a, a Big Mac (laughs)…and it was like, "okay no"…I can't do that, but it was….just negotiating the small things…Being aware of them at the very beginning because otherwise it could've just… "Oh,

well, actually (practitioner name) always buys me a Big Mac every week"…you don't know where these things could go" (Participant 2)

Process of navigating boundaries over time

Assessing

"so for somebody that's engaged historically really easily and that perhaps, has a lot of demands of the service…I'll be starting at a different point that will end up meeting in the same place to with someone who is only doing this because they've been told they have to, for example" (Participant 6)

"I think especially with, at the beginning, 'cause you don't know people, um, and then over time, you might become a bit more jokey with them" (Participant 1)

Engagement/building rapport as primary task

"*we invest a lot of energy into the engagement, early engagement*" (Participant 9)

"I think, going in too early on without due reason with that sort of, conversation I think it might, it might hinder the uh, the relationship the sort of engagement" (Participant 9)

Designing the relationship

"a consideration about their past experiences, documentation about previous engagement with services. Has there been any issues before? Do I know of any emotional or attachment issues or relationship issues, instability issues which…I may have to consider when designing the kind of relationship we're gonna have?" (Participant 7)

"working with younger people I tend to be more boundaried?...and put that in place right from the very beginning, um and then if need be, you can relax it as you get to know them slightly if, if necessary, whereas um, yeah, I think perhaps with sort of older clients, at times you can be a bit more relaxed from the beginning?" (Participant 2)

"there's always gonna be a, no matter probably how experienced I am there's always, there's always a bit of an unknown that, am I being strict enough and or am I being structured enough with this person, because you never really know…You don't know them well enough to know, a hundred percent, this is the right approach" (Participant 7)

"*I probably take more of a…directive approach with him in a way…it is a different sort of…relationship…And that's what seems to work…with him*" (Participant 10)

Communicating boundaries to client (implicitly or explicitly)

At the beginning…. building a relationship with the person…and making it clear what that relationship is" (Participant 1)

"so that's when you take it to the team…. then they'll say "why don't you have a conversation about it and see what, you know, make that explicit?" (Participant 6)

"early on…we might outline what the remit of the service is and what we can and can't offer and what we can and can't achieve…But in terms of sort of professional boundaries and…self-disclosure…I think it's, I think it's more nuanced than that" (Participant 9)

"*I probably take more of a…directive approach with him in a way…it is a different sort of…relationship…And that's what seems to work…with him*" (Participant 10)

"we work with people for…a considerable period of time, but…Not for their whole life…You've got to make them aware you're here three years…but actually what happens when we go…Um, yeah I guess and what's going to be there afterwards?" (Participant 3)

"you almost have to justify it by, put a caveat in by saying, you know, I have to say this to everybody kind of thing, because it just seems completely not congruent with the, the tone of the conversation?" (Participant 7)

Recalibrating/altering the relationship

“but certainly if, if things do overstep the line then I’m confident to challenge that and raise that, yeah” (Participant 2)

“*you've always got to have that in the back of your mind that you think you've probably assessed the situation correctly and this is an appropriate level of personal, you know, relationship”* (Participant 7)

“she'd say things at the end of conversations like, “love you” and like you would with a close friends…And it's really hard...‘cause I did feel a bit of love for her!...Because it was very sort of maternal relationship….it possibly is something I should have challenged her about? but I just didn’t? So I just didn't reciprocate…I think it was probably obvious that I wasn't doing the same…I’d be like…take care…just reply with something friendly, but not as forward” (Participant 8)

Navigating endings

“*so that’s when you take it to the team and say, “ooh how, how do I manage this?” And everyone will have been through it. So then they'll say “well, er you know you could get, why don't we introduce someone else in the team to start getting ready for discharge”* (Participant 6)

“we work very closely with some people for three years and at the end of it you say, right that’s it now. And you’re thinking well I’ve got to say goodbye now, this isn’t going to be any good, and they say “ok bye” and close the door, and you’re like (facial expression, laughs).” (Participant 1)

“Yeah, and my colleague, that same colleague, we both worked with someone in (name of town) and, you know, it-it he had so much input and then he had exactly the same experience with that person, he said, okay, that's the end and he just went “yeah bye” and closed the door. And it makes you, and he called me up cause he was like “I can't believe it” you know” (Participant 1)

“I think I think it's harder, it’s harder when it's like a, a more unhappy ending I think (Mhm?) Is, is what's harder for me I think, um where you kind of maybe think urgh, could you know, could we have done more or um, you know, that's, that's a harder, um ending I think” (Participant 10)

“I know they're fine and I know I'm fine but, there hasn't been that ceremonial (Mmm) Official ending I suppose, that closure.” (Participant 6)

“I was almost a bit like, I was a bit confused or a bit worried that I hadn’t, or that maybe I'd done something wrong or I hadn't, handled it in the best way because, it seemed like he just kind of was happy to disengage without making too much of a fuss. Didn’t really even want to meet up kind of thing” (Participant 7)

“some of them just disappear and you never see them again. And you think, yourself, you know, didn't didn’t didn’t we mean anything to you (laughs), EIS?” (Participant 1)

“Or that I saw it, I was allowed to see that it was” (Participant 7)

“And you unfortunately are a, um a thing that's no longer useful” (Participant 7)

“it just seems really weird that after working that closely with someone for three years, suddenly it's like, see you later. (Yeah) What, I can’t contact you again, really.” (Participant 7)

“But it's quite hard to not get in touch? (Yeah) Like normally I would be speaking to her- I'd have it in my diary that I’d speak to her once, but we’d inevitably speak a lot more than that or text or message or email or all sorts” (Participant 8)

“I mean, I guess you could check in on a professional level and see how they are and, you might say hello if you pass them in town, but (Yep) You, you're living in the same town as someone, you might see them really often (Mmm) You’ve been seeing them two, three times a week for the last couple of years and then suddenly that all finishes and, yeah, it’s a bit of a weird one really” (Participant 7)

“that's always really interesting when you notice how much, the temptation is there just to call up your old colleague and say “oh how are you doing? Oh, and also how’s (laughs) this person doing?” (Participant 6)

"Yeah yeah there was, definitely. I mean also people were expressing themselves in text messages (Mmm) In a way that wasn't coming through in real life, you know?" (Participant 8)

"I think you kind of just have to, that's just the way it is, isn't it? I think um, you kind of have to wish, you wish them well on that last appointment and, kind of, say "it's been an absolute" I've so yeah, I've, I've kind of said that, you know "Do you know what, I've loved working with you" (Mhmm) "I've loved getting to know you" (Participant 10)

"and kind of, you know, talking about their, their future with them and thinking saying "you know, you've got, you know I just hope that everything goes really well" and I think it's that kind that's how I would tend to, end things with people" (Participant 10)

You've got to make them aware you're here three years, but actually what happens when we go and you know that attachment-so…the boundaries are important because they need to know how long that relat you know that particular relationship is gonna be there for…and what's going to be there afterwards?" (Participant 3)

Appendix 21: End of Study Summary Report for Participants and Ethics Panel

Dear [participant],

Thank you for participating in my research project regarding the navigation of boundaries within Early Intervention in Psychosis Services. Your contributions were extremely valuable and insightful.

I am writing to provide you with a summary report of the project. In addition to this, you are welcome to request a full copy of the report using my contact details at the end of this report. I am also happy to receive any questions, thoughts, or feedback you might have.

Background:

Early Intervention in Psychosis Services (EIPS) is a unique service model for people experiencing a first episode of psychosis. They are intensive, case-management services which adopt an assertive outreach approach, employing flexible boundaries to meet clients in the community and support them towards recovery and holistic goals. Current boundary theory is therefore not easily applied to this clinical context.

Aim:

This study aimed to develop a model, or theory, to understand how CMs in EIPS develop their understanding and practice around navigating boundaries, given the inherent challenges with this clinical population and service model.

Method:

Participants were 13 EIPS case-managers. I tried to recruit participants with a range of demographic characteristics (e.g., age, gender, ethnicity, profession, years qualified). Semi-structured interviews were undertaken with participants, and were transcribed and analysed by the researcher using a grounded theory methodology.

Grounded theory analysis involved grouping findings by categories and subcategories (like themes and subthemes) in tangent with conducting interviews, so that my findings could inform questions I asked in further interviews. Analysis used a constant comparison process, in which current categories and subcategories were constantly being compared across all of the data to ensure the results were reflective of most participants.

Once the model/theory was developed, it was checked out with a subset of participants to get their views and feedback on the model. This was then incorporated into the final model.

Results:

Findings led to a circular concentric model which defined different layers of influence impacting case-managers navigation of boundaries:

- Professional bodies/organisation policy
- factors and challenges specific to EIPS culture
- Team processes
- Individual decision-making processes

Within each of these layers are subcategories relevant to the navigation of boundaries in that layer, such as "sharing decision-making" within the team processes layer.

- Additionally, some processes took place across layers, for example the "Learning and Calibrating cycle" was a process of learning/calibrating boundaries for case-managers not only from their own clinical experiences, but also from interactions with colleagues and the EIPS culture.

- The model intends to convey that navigating boundaries in this context is a dynamic interaction; there are links between the layers of influence, and many of the subcategories are connected. Earlier versions of the model involved many arrows conveying these connections, however this made the model too busy and confusing (so bear in mind that layers and subcategories are closely related).

- The pink box positioned outside of the circles, represents case-managers prior experiences, or influences which they carried with them into this role. It was clear that case-managers had a natural, or innate "stance" around boundaries which fell somewhere along a spectrum; some case-managers naturally tended towards stricter, rigid boundaries, and others tended towards looser, more flexible boundaries. This in turn was influenced by prior clinical experiences and conversations with clients and professionals, for example during professional training.

- Another way of interpreting the data was by conceptualising case-managers process of navigating boundaries with clients over time (the fixed 3-year timeframe), and the different challenges arising at different points within this process as boundaries evolved. Therefore, a timeline is presented along the bottom of the model with subcategories outlining the different stages of navigating boundaries. Note, as with the concentric model, this is a dynamic process and there is movement between stages (indicated by arrows), meaning case-managers and clients can move back and forth between them.

The model is shown on the next page. Following this, for those interested there is some further detail about the EIPS culture layer and subcategories.

Discussion and conclusion:

This model has highlighted how case-managers navigate and design boundaries with clients using a flexible, case-by-case approach, which varies over the course of the EIPS timeframe. The benefits of this approach were that case-managers were able to present their authentic selves and work within their own moral principles, build meaningful relationships, and better support client-centred, goal-oriented recovery for clients experiencing high levels of distress. This was facilitated by features of EIPS culture, and team processes.

Challenges, which were many and varied, were overcome through consultation with the team or colleagues, with shared decision-making, reflection, and collaboration around boundary decisions, meaning clinicians did not feel left holding this complexity on their own. This scaffolded participants' learning and confidence in their own clinical practice, enabling them to navigate boundaries in this more nuanced fashion.

Most of the boundary dilemmas experienced by case-managers within EIPS fit with the concept and theory around boundary crossings (Gutheil & Gabbard, 1998). This suggests that broad guidelines and principles are helpful (such as professional codes of conduct, or principles such as considering the motive for a boundary crossing). However, the justification for, and impact of a boundary

crossing (including whether it becomes a boundary violation) can only be assessed through careful attention to the clinical context, and idiosyncratic circumstances.

Participants in respondent validation interviews recognised the value of this model as a clinical tool to guide case-managers thinking when making difficult boundary decisions, and for reflection around boundaries, both on an individual basis and within teams. Findings suggest clinical implications for how case-managers can jointly construct appropriate boundaries with clients, and discuss dilemmas using the team as a resource.

For further information on any of the other parts of the model, or for a copy of my full report, please feel free to contact me.

Researcher contact details:

Alexandra Bone

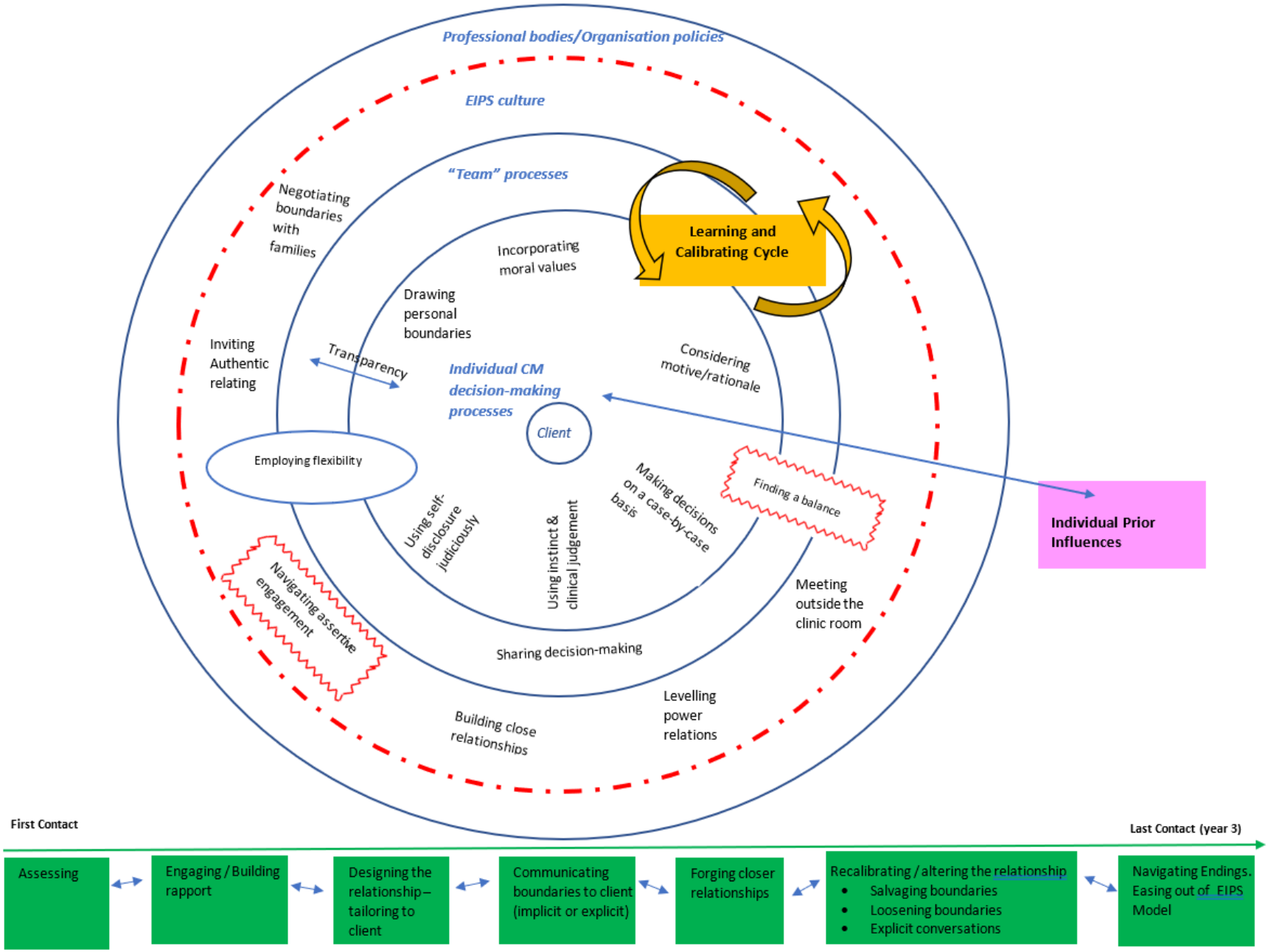
Trainee Clinical Psychologist

Salomons Institute for Applied Psychology

Canterbury Christchurch University

University Email: ab1281@canterbury.ac.uk

NHS email: Alexandra.Bone2@nhs.net


Professional bodies/Organisation policies
EIPS culture
"Team" processes
Negotiating boundaries with families
Incorporating moral values
Learning and Calibrating Cycle
Drawing personal boundaries
Inviting Authentic relating
Transparency
Individual CM decision-making processes
Considering motive/rationale
Client
Employing flexibility
Finding a balance
Individual Prior Influences
Making decisions on a case-by-case basis
Using self-disclosure judiciously
Using instinct & clinical judgement
Navigating assertive engagement
Meeting outside the clinic room
Sharing decision-making
Levelling power relations
Building close relationships
First Contact
Last Contact (year 3)
Assessing
Engaging / Building rapport
Designing the relationship – tailoring to client
Communicating boundaries to client (implicit or explicit)
Forging closer relationships
Recalibrating / altering the relationship
Salvaging boundaries
Loosening boundaries
Explicit conversations
Navigating Endings. Easing out of EIPS Model

Further information about EIPS Culture Layer

This layer represents how the culture within EIPS was a significant influence on how CMs navigated boundaries with clients, and, in itself posed benefits and challenges around navigating boundaries.

Navigating Assertive Engagement

A key tenet of the EIPS model is assertive engagement. Participants discussed being heavily invested in engagement, and the importance of this approach with people experiencing psychosis.

"*some services may say…they didn't turn up, and then we sent another appointment letter and they didn't turn up…if we were to…strictly stick to that boundary and not assertively go and approach that client in different ways…we would lose fifty percent of our clients…they just wouldn't get a service*" (Participant 11)

However, this sometimes came at a cost of difficulties maintaining either the clinician or the client's boundaries. A tension was navigating the fine line between engaging versus harassing; how to assertively engage whilst respecting client's own boundaries, or when to step back. "*There's been scenarios where…we've made decisions as a team to contact employers…that's a significant boundary to…cross…there's something about the assertive model…that influences how far we encroach on the service-user's boundaries*" (Participant 9)

Meeting Outside the Clinic Room

This was a strong feature of EIPS. Meeting outside the clinic room was a means through which many processes related to flexing boundaries (navigating assertive engagement, levelling power, building close relationships) took place. Most participants expressed the benefits of working in this way, enabling the same "work" to take place in a way which was more flexible, and suited to the client's needs and goals (e.g. going to a café if a client wanted to become more confident in social situations, or taking exercise together if a client wanted to lose weight). "*I might go for a walk with somebody and I might be doing the same work, but if I sat in a clinic room you would never…be able to work successfully in in that way*" (Participant 10) Some participants also used shared interests as a means to meeting clients (going to the gym, or for a bike ride).

However, meeting outside the clinic room could also raise questions about whether clinicians' boundaries still held precedence when in communal spaces, and often a negotiation, or compromise around boundaries took place.

Levelling Power Relations

All participants either explicitly or implicitly referred to the power dynamics in the client-clinician relationship. EIPS advocates a flattened hierarchy, minimising the inherent power imbalance between clinician and service-user. Flexible boundaries (more tailored to the wants or needs of the client) was a way of levelling power. "*you're trying to minimize that power dynamic as much as you can which means being more flexible with the boundaries*" (Participant 6)

Often participants tried to minimise the power imbalance by taking a collaborative approach with clients, jointly constructing boundaries.

"*having…open conversation about…how do you want that set up?...Be open and honest and transparent about the fact that we need to have boundaries…but actually, how do you find that and what do you want*" (Participant 3)

However, this was often complex in practice. Participants acknowledged that, ultimately, they still held more power, information, and duty of care responsibilities, which they could use to invoke

restrictions on client's liberties. Some participants reported experiences whereby clients appeared to value the professional boundaries and responsibilities still present; wanting or expecting the clinician to provide control and safety.

Inviting Authentic Relating

This subcategory was related to using self-disclosure, although encompasses a broader sense of bringing one's authentic, genuine self into clinical work. This often involved expressing their emotions and human responses to clients (and sometimes, but not always, included self-disclosure), which indirectly loosened boundaries. *"Making yourself human and…a real person…just showing that*" (Participant 6)

Participants felt that bringing aspects of their real selves into the relationship invited clients to reciprocate. Some felt that if they were not relating authentically with this client group, this led to more traditional "patient-professional" roles and boundaries, in which the client did not meaningfully engage. *"I'm asking them about their kids…their life…to share it in…intimate detail and if I'm not prepared to…be a human as well who has similar experiences…it just feels a bit disingenuous" (Participant 7)*

Building Close Relationships

Due to the intensive nature of EIPS treatment, participants spoke about building closer relationships with clients; being part of their recovery journeys and personal growth. This was linked in with the notion of standing alongside clients, positioning themselves as an ally or supporter.

"we've been on a journey here…I've seen you grow…a couple…they were street homeless…we've been able to support them with housing and, employment and, getting their driving licence back" (Participant 9)

Closer relationships meant participants could struggle with implementing boundaries when they had a naturally strong alliance with a client. This was reflective of the fine line between being a supporter versus a friend, and was complicated by use of more informal communication methods, such as texting or WhatsApp. This concern was particularly present when clients did not have any other support or social networks around them. "*It's kind of what you would do with your mates…we're a little bit maybe more relaxed about what we're actually saying and sharing and how often you're communicating and texting on WhatsApp*" (Participant 8).

In response to this, participants spoke about remaining cognisant of professional boundaries, whilst still allowing for a rapport. However, there was a sense for some participants that even if they felt they had drawn the boundary successfully between friend and supporter, they could still not always control how the client perceived (or wanted to perceive) them. "*if I'm in somebody's life in a professional capacity for three years and they feel that they want to share a lot with me…the boundaries may be blurred for them…even if I feel I'm managing it*" (Participant 5)

Negotiating Boundaries with Families

There could be tension in managing concerned families' expectations of boundaries, and marrying this with the assertive engagement way of working in EIPS. "*it's quite hard I think sometimes to explain to parents about building rapport…parents might expect you to go in and sit there with that clipboard and be seen by them to be doing something that's very…medical model focused*" (Participant 1)

As a result of becoming involved in many aspects of clients lives, and CMs often undertaking family interventions (FI) as well as individual work, determining where to draw the boundaries around

confidentiality and how much to share with family members was a challenge. Sharing information could be helpful for families, but have repercussions for clients' in feeling as though their personal boundaries had been overlooked.

Sometimes, this challenge extended to boundaries around information-sharing within the team, and balancing this with the realities of family's lives.

"*boundaries put in place…I'm gonna work with him and you work with the brother…to the extent where when one of them is being discussed in MDT…other people leave so that they don't hear…although that might be a safer way of working…that's just also not reflective of…how those families are experiencing their lives together"* (Participant 6)

Appendix 22: The Process of Navigating Boundaries Over Time in EIPS (Timeline)

Assessing (First Contact)

At first contact, when participants were in the process of assessing clients for the service, participants described also assessing the client to consider what kind of boundaries might be most appropriate for the client.

Generally, if clients seemed reluctant or unsure about engaging with the service, looser boundaries would be employed to facilitate engagement. However, certain client characteristics (such as if a client had particular attachment difficulties, or an autism spectrum disorder) sometimes suggested to participants that employing more explicit, firm boundaries from the outset would be most helpful. "*I very much gauge it on how the individual is towards me maybe on first or second contact…Sometimes, it's appropriate to be more explicit, and just to lay out*" (Participant 13).

Engagement/ Building Rapport as Primary Task

In-keeping with the principle of assertive engagement, participants described their primary task as engaging clients and building rapport. In doing this, most participants employed looser boundaries at this stage to compensate for those clients who did not feel they wanted help, or felt quite fearful or mistrusting. Many participants felt that having explicit conversations about boundaries in strict terms hindered engagement with such clients, and so would only do this if the need arose. If it did not, the concept of boundaries was introduced at a later stage in the relationship once good engagement and rapport had been established.*"You, focus on the engagement first and the boundaries second"* (Participant 6). "W*e, won't make those boundaries very explicit at the beginning and we kind of just fit in with wherever that person is in their lives…in I guess in the least obtrusive way"* (participant 7).

Designing the Relationship – Tailoring to Client

As participants got to know clients, many described a process of negotiating, or designing the relationship, and with it the boundaries, with that particular client. Some participants had general principles around boundaries they employed, for example tending to have tighter boundaries with younger clients, and more relaxed boundaries with older clients. Some participants described this being a negotiation between both parties to an extent (for example what activities they did together, or how the client communicated with the participant). Clients' idiosyncratic histories were also considered by the participant (for example patterns of engaging with services, emotional or attachment difficulties) when designing the boundaries of the relationship.

*"Meeting different people with different ways of, of negotiating it 'cause it, it's all it's just this kind of, like constantly moving thing and it's, it's a negotiation. It's a very live active thing of like how do you negotiate the boundary…how do you negotiate the, the relationship" (*Participant 11).

Communicating Boundaries to Client (Implicitly or Explicitly)

This stage was closely linked to designing the relationship with clients. Within most client relationships, once engagement and rapport had been established, there came a point where certain boundaries (of the service and individuals) needed to be communicated to clients. Whether this was done through an explicit conversation around boundaries, or through more implicit or sensitive means was dependent on the individual client and the idiosyncratic client-CM relationship. "*You've got to make them aware you're here three years…the boundaries are important because they need to know how long…that particular relationship is gonna be there for*" (Participant 3).

Forging Closer Relationships

Within EIPS, close relationships with clients are formed. As participants and clients developed these closer relationships over time, boundaries were sometimes loosened, and this could be accompanied by complex boundary dilemmas. (See "Building close relationships" subcategory for more details).

"she'd say things at the end of conversations like, "love you" and like you would with a close friends…And it's really hard...'cause I did feel a bit of love for her!...Because it was very sort of maternal relationship" (Participant 8).

Recalibrating / Altering the Relationship

As boundary dilemmas arose, often participants had to "recalibrate" or alter their relationship with clients. For most participants this involved implicitly or explicitly introducing firmer boundaries, or deciding where to draw the line. However, for those participants who started with tighter boundaries, this process could involve loosening boundaries.

"*I had to then…bring in boundaries which he found a bit odd because that hadn't been how we're working? but it hadn't presented an issue until that point…So I then had to, kind of say, well like that's where the line is I can't really…Do that*" (Participant 7).

Navigating Endings

Towards the end of the 3 years, participants prepared for the ending with clients. Often this involved tightening certain boundaries (e.g. reducing the amount of contact participants had with clients), in order to prepare clients for the level of support they would receive after EIPS (which was

likely to be far less; referred back to the GP or onto secondary mental health services). However, there was sometimes a loosening of boundaries at the very end, for example hugging clients when saying goodbye, or communicating on a deeper, more personal level. Participants described struggling with endings themselves, finding it difficult to come to terms with the complete cut-off of the relationship, and not knowing how clients were doing afterwards.

Sometimes participants' hopes and expectations of endings were disappointed where clients felt unable to face the ending, or preferred a more detached goodbye-inserting their own personal boundaries.

"S*o that's when you take it to the team…they'll say "well…why don't we introduce someone else in the team to start getting ready for discharge*" (Participant 6).

"*We're expecting it to be, er this almost blurring of the boundaries there. Even though we've tried to keep to it*" (Participant 1).

"*Some of them just disappear and you never see them again. And you think…. didn't…we mean anything to you (laughs), EIS?"* (Participant 1).

Appendix 23: Factors in CMs Individual Decision-making Around Boundaries Within EIPS

Making Decisions on a Case-by-case Basis

How participants "designed" the boundaries with individual clients was, to an extent, decided on a case-by-case basis, considering the individual's idiosyncratic context and circumstances.

"It's…a consideration about their past experiences…previous engagement with services. Has there been any issues before? Do I know of any emotional or attachment…relationship… instability issues which…I may have to consider when designing the kind of relationship we're gonna have?" (Participant 7).

Client-specific factors included the client's attachment style and ways of managing interpersonal relationships, their history of engaging with services, and risks. "*It's based on circumstances…I wouldn't be offering to do everybody's washing…unique scenarios call for unique thinking*" (Participant 12).

More day-to-day boundary dilemmas which arose were made along similar lines, although idiosyncratic circumstances and the CMs' rationale were considered.

Many participants expressed the cognitive and emotional burden of making boundary decisions on a case-by-case basis, as opposed to having blanket rules. "*We're…encouraged to take every…boundary decision on a case-by-case basis, I think that can be quite exhausting*" (Participant 6).

Using Instinct/Clinical Judgement

All participants referred to using an instinctive, gut feeling around boundaries with clients; what felt comfortable or uncomfortable. This guided CMs' decision-making, although there was recognition that occasionally a boundary crossing may feel uncomfortable, but still be the best option.

"*If something doesn't feel quite right, then it probably isn't…then I guess one has to think about…even if it's not quite right, does it still need to happen, and what would be the consequences?"* (Participant 12).

Participants used their clinical judgement (which developed over time), to make such decisions by: drawing on past experiences with clients, considering the likely consequences of crossing versus not crossing a boundary, particularly the impact on the therapeutic relationship and engagement versus risks. *"That tacit knowledge of…what's been helpful in…previous experiences…what the value is in…maybe pushing the boundaries a bit…Versus the, the risk of*

pushing the boundaries." (Participant 9). Often if a boundary was crossed, attention was paid to the safest way in which it could be crossed.

Considering Motive/ Rationale

Participants emphasised the importance of considering their rationale, or underlying motive behind making boundary decisions within grey areas, and ensuring their motive was for the client, rather than themselves.

"*So, I weighed it up and I broke this boundary…"but you know my rationale was, she desperately does need this respite"…It was difficult for me to find somewhere else that I could do this laundry in work time in a work environment*" (Participant 12).

Many participants also explored what might be going on for the client when relationships strayed into more grey areas, or looked out for small signs indicating something about the client's underlying needs, motives or attachment style. In these instances, whether boundaries needed to be adapted was considered. "*In…shifting the boundary, is this gonna be therapeutic? Is this going to be helpful? And…who's it for?...Is it for me? or is it for them?*" (Participant 9).

Using Self-disclosure Judiciously

This was an important subcategory in relation to boundaries for all participants. The EIPS culture (building close relationships, authentic relating) meant that CMs were more likely to self-disclose. "Y*ou get to know somebody a lot better and in doing so you'll have many more conversations…I'm much more likely to have…shared something at some point in one of those conversations*" (Participant 3).

Participants felt that unnecessary barriers to building rapport were formed by maintaining rigid boundaries around self-disclosure, particularly in response to client's questions. However, within this there was a spectrum regarding how much individual participants felt comfortable, self-disclosing. Some participants were likely to intentionally self-disclose for a specific therapeutic benefit, such as normalising, or sharing strategies (for example around parenting).

"I *might give an example like, if I say to my children "tidy up your room, pick all those clothes up" (pretend shouting) they're likely to completely ignore me…But if I say…'are you guys going to get round to sort of tidying this bedroom up a bit?', and…'do you want to bring your washing down?'…They're probably gonna respond to that. So I might use that kind of example"* (Participant 12).

There were also reasons not to self-disclose certain information with certain clients. These reasons included: to maintain focus on the client, not risking burdening the client, preventing an imbalance in the relationship (if a participant had things in their life the client did not, for instance), allowing the client to use the CM as a therapeutic object enabling them to think of the CM in the most helpful way for them.

A general rule of thumb was: How helpful versus unhelpful would it be for them to know this information?

Several participants also sought permission from clients before self-disclosing more personal information. *"You say "well, do you mind if I give you this information?"...because they might not want to hear that actually…they might not think that's helpful"* (Participant 3). In response to self-disclosure requests from clients, participants sometimes deflected questions they did not want to answer (e.g., "when is your birthday") with humour, or explored the meaning or purpose behind the question with participants. *"I kinda give a quite vague answer?...oh I'm a…winter baby…that's how I probably navigate it. I'll give a certain amount of information but then keep a lot of it more generic" (Participant 10).* If they felt it would harm the therapeutic relationship not to answer the question, participants often responded in vague terms or had stock answers, which allowed for authentic relating whilst maintaining safe boundaries.

"*If you…start talking too much about…your own personal life or, or experiences…that can kind of be intrusive to the person, using you as a therapeutic kind of object?...they need to…interpret you…in a way that…is helpful for them not…and sometimes like bringing in your own reality can be really intrusive and unhelpful*" (Participant 11).

The other element pertinent to self-disclosure was considering clients' mental state. Participants were wary of "feeding in" to overvalued ideas or delusional belief systems, resulting in an interesting dilemma: participants may have relaxed boundaries and self-disclosed more to clients when they had fewer psychotic experiences, but this had the potential to be problematic if clients' experience of psychosis worsened. *"had I met him at a point in his illness where he was more unwell, I might not have discussed so much about my own … life interests and outlook and history and things like that." (Participant 4).*

Similarly, when clients presented as more psychotic, some participants were mindful of how much clients were self-disclosing to them, wanting to protect clients' personal boundaries on their behalf if this felt out of character for them, or they questioned their capacity to decide to self-disclose such information.

"*When somebody is…very psychotic, if they were sharing something that I felt they would not want me to know in…normal and… "hibited life" I would try and have that kind of conversation with*

them…what the capacity is to make a decision to share that information in that moment." (Participant 5).

Drawing Personal Boundaries

In addition to the higher governing layers, and working within EIPS culture, participants drew their own personal boundaries. CMs sometimes had personal preferences regarding who they worked with relating to boundaries, or "red lines" which they would never cross, even if it were professionally permissible. "*People are allowed to receive gifts up to a certain limit…And it is quite…a high limit. I personally don't agree with that…So that would be against my own personal boundaries*" (Participant 12).

In some cases, participants' personal boundaries related to experiences in their personal lives, and concerns around the emotional impact of this for them, or unhelpful transference. *"I don't tend to work with many female clients…it's something that I don't personally feel particularly comfortable with*" (Participant 4).

Incorporating Moral/ethical Values

Participants often incorporated their own moral/ethical values and beliefs when making boundary decisions. *"I try and treat people how I wanna be treated"* (Participant 12). This meant CMs sometimes went above and beyond the boundaries of their traditional professional role to support clients.

"*He'd…Lost his visa, because he'd been to prison…But he'd been to prison because he was psychotic but just wasn't picked up…with people like him…I think…there's like a moral duty to actually do something about it rather than just leave it…And he would end up getting deported*" (Participant 1).

However, incorporating one's own moral values was complicated in greyer areas concerning boundaries, and there was often tension between CMs own moral compass, and professional or organisational codes of conduct.