A Qualitative Study of Trainee Boundary Difficulties in Psychotherapy

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Abstract

This is a qualitative study of trainee psychologists' experience of boundary difficulties in psychotherapy. Rooted in the paradigm of phenomenology, the study employed an idiographic focus and assumed a hermeneutic stance. It used semi-structured interviews for data collection and an interpretative phenomenological analysis of the transcripts. The study aimed to answer the following research questions:

a) What boundary difficulties do trainees experience in psychotherapy?
b) How do trainees make sense of and manage boundary difficulties in psychotherapy?

The participant sample was Masters level student psychologists at the University of KwaZulu-Natal. The results of the study identified thirteen emergent themes and five superordinate themes. The emergent themes were as follows: professional role, space, physical contact, working with children, supervision, managing time, gifts, self-disclosure, use of language, trainee anxiety, feelings evoked, reflective practice and choice of clothing. They capture the areas related to boundary difficulties mentioned by the trainees. The superordinate themes were as follows: (1) boundaries as the rules, (2) boundaries as scaffolding and (3) boundaries as a security net, as well as (4) difficult decisions and (5) learning from the experience. The superordinate themes captured the trainees' experiences of difficulties, identifying the concept of boundaries as being the rules, their function as being a type of scaffolding and their form as a security net for trainees. Trainees' difficulties were around the decision-making process when negotiating boundary-related issues. Trainees experienced the difficulties as learning opportunities made possible by reflective practice and supervision.

Key words: qualitative research, interpretative phenomenological analysis, trainee psychologists, boundaries and boundary difficulties

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CHAPTER ONE

INTRODUCTION

This chapter describes the motivation for this thesis. It addresses the aim and purpose of the study as well as its importance. The chapter also outlines the structure of the thesis.

Motivation

Boundaries set the stage for all therapeutic work. They are the 'ground rules' (Langs, 1988) that determine and influence the course of psychotherapy. Although context specific, boundaries guide therapeutic interaction and are ubiquitous across all treatment models and formulations. Establishing appropriate and effective boundaries, as well as maintaining them are important skills for all psychotherapists. Boundaries are not specific to psychotherapy. They exist in all interaction between individuals, families and communities.

In both psychotherapy and non-therapeutic contexts, boundaries offer a guide and framework for interaction that is mostly learned from experience. Gutheil and Gabbard define boundaries as "the edge of appropriate [therapist] behaviour" (1998, p.410). The concept of boundaries in a therapeutic context will be defined and expanded on in the literature review (See Chapter 2).

Understanding boundaries in psychotherapy is particularly important for trainees who, as novice psychotherapists, are discovering what boundaries are and what they mean in the therapeutic context. Trainees are also at a stage of development where they can explore and learn through experience. Making boundary-related decisions, they can make sense of boundaries, find areas within which they are comfortable working, which they are good at and with which they have difficulty. Negotiating and managing boundary-related difficulties in a supported training environment offers an opportunity for trainees to make decisions and make mistakes within the training setting and with the guidance and support of supervision. Trainees learn from these early experiences in their development as professionals and it is especially important to understand their difficulties as this is where boundary management begins (Hermansson, 1997). In addition, Bhola, et al. (2015) advocate for the need to explore boundary difficulties

experienced in the early phase of professional development to gain an understanding of how knowledge of professional ethics and boundaries in psychotherapy translates into action.

Understanding how trainees make sense of their boundary difficulties can be used to inform training programmes where trainees are taught to think about boundary related decisions. It can identify and motivate for the importance of providing opportunities for trainees to explore and experience boundary difficulties early in their development as psychotherapists, particularly with the support of supervisors. Understanding the process of negotiating boundaries in the early stages of development will lead to future psychotherapists being more informed and better equipped to manage boundary related difficulties.

Aim of the study

This thesis set out to explore trainee psychologists' experiences of boundary difficulties in psychotherapy. The thesis aims to understand what boundary difficulties trainees experience in their therapeutic work with clients and also will explore how these trainees negotiate such boundary difficulties.

Purpose of the study

Like all psychotherapists, trainees are faced with boundary-related difficulties in their therapeutic work. Managing boundaries may often appear to be straightforward, however, boundaries have a deeper complexity that usually only comes to the fore when experienced and discussed. This study is relevant because trainees are in the process of learning about boundaries in psychotherapy. They are engaging and participating in facilitated discussions related to boundaries and boundary difficulties, and they are supported in learning how to make boundary-related decisions.

Importance of present study

A part of becoming a psychotherapist is learning how to make boundary-related decisions. Boundary decisions are an intuitive cognitive process that deepen trainees' understanding of the therapeutic process. A conversation about boundary difficulties is

necessary for the development of trainee psychologists, serving as an integral element of their training. Understanding trainee difficulties with boundaries in therapy allows for the difficulties to be addressed and guides the appropriate development of the necessary skills required for making boundary-related decisions in therapeutic work. Boundaries need to be understood, respected and reflected upon. Boundaries are a topic to be discussed and explored in all their complexity, across the continuum of development.

The findings of this study are important because they offer an endemic understanding of trainee specific boundary-related difficulties. The findings illustrate how trainees makes sense of boundaries in psychotherapy and how they understand their function and form in the therapeutic context. The findings also offer insight into trainees' experiences of the decision-making process and highlight their areas of difficulty, as well as how they could learn from their experiences.

Research questions

This research study qualitatively explored trainee boundary difficulties in psychotherapy with the following research questions in mind:

a) What boundary difficulties do trainees experience in psychotherapy?

b) How do trainees make sense of and manage boundary difficulties in psychotherapy?

Structure of the thesis

Chapter two. The literature review will introduce the concept of boundaries in psychotherapy. It will offer a definition and briefly explore boundaries from a psychodynamic orientation as well as from a behavioural therapeutic stance. The chapter will discuss how boundaries form a therapeutic framework and it will identify types of boundaries as outlines and discussed by Gutheil and Gabbard (1998).

Chapter three. This chapter outlines the methodological approach used in this study. It presents the research design and rationale. It briefly outlines the approach used and discusses the processes of sampling, data collection and data analysis. The chapter also presents the ethical considerations and procedural rigour.

Chapter four. The findings present the research participants' experiences of boundary difficulties. It presents the themes that were identified through the process of IPA. Thirteen emergent themes were derived from the data analysis (See Table 1). These informed the development of five superordinate themes, each with subordinate themes that represent the essence of the participants' experience (See Table 2).

Chapter five. The discussion outlines the key findings of the research and explores them in relation to the wider literature.

Chapter six. This chapter concludes the thesis. It offers an overview of the process followed to achieve the research aims and links the findings back to the research questions. It also outlines the implications of the study, discusses its limitations and offers recommendations for the future.

CHAPTER TWO

LITERATURE REVIEW

The literature review will introduce the concept of boundaries in psychotherapy. It will offer a definition and briefly explore boundaries from a psychodynamic orientation as well as from a behavioural therapeutic stance. The chapter will discuss how boundaries form a therapeutic framework and it will identify types of boundaries as outlined and discussed by Gutheil and Gabbard (1998).

Thesis statement

Boundaries in psychotherapy are important for both the therapist and the client. This is because boundaries outline and determine the nature of interaction that is acceptable in therapeutic work (Audet, 2011). Clear boundaries ensure ethical appropriateness. How boundaries are managed in psychotherapy determines and influences the development of the therapeutic relationship and the potential outcome (Pope & Spiegel, 2008). All therapists are faced with boundary-related decisions and difficulties in their therapeutic work. Trainees alike experience boundary difficulties, and these interactions and decision-making opportunities form part of the learning process of becoming a psychotherapist (Hill, Sullivan, Knox & Schlosser, 2007).

Rationale

Understanding the boundary-related difficulties that trainee psychotherapists experience is important because training experiences provide the foundation for subsequent learning (Hill et al., 2007). Trainee psychologists at the beginning of their careers are faced with navigating boundary-related concerns in their therapeutic work and learn through experiencing both the process and importance of establishing and maintaining ethically appropriate boundaries in all aspects of their therapeutic work.

Defining boundaries in psychotherapy

Allan (2011) explains that the norms of law, positive morality and professional ethics primarily define boundaries. A few theorists have offered definitions of boundaries in psychotherapy. Audet (2011) explains that boundaries are factors that outline or delineate interpersonal interaction that is ethically appropriate in therapeutic work. Allan (2011) describes a boundary as "an imaginary line between behaviour that is generally appropriate when a therapist acts in a professional capacity, and behaviour that is not" (Allan, 2011 p. 170). Other theorists have defined boundaries as the 'parameters' within which the limits of a relationship between a psychotherapist and client exist (Aravind et al., 2012; Bridges, 1999; De Sousa, 2012; Pope & Spiegel, 2008).

Boundaries in psychotherapy and the definitions of boundaries are relative. Definitions for boundaries in therapeutic work are varied, as they are a result of individual circumstances dependent on several factors specific to the patient, the therapist, the therapeutic alliance and the treatment approach (Simon, 2011, p. 287). Some factors include the client's needs or his/her personality, which lead to considerations such as "is he/she open, trusting or vulnerable?" A therapist may consider what is clinically useful and ask "What type of boundaries will assist and which will hinder the therapeutic process?' A factor such as the reason for referral, 'Is this an assessment? or therapy?", may influence the treatment plan a therapist chooses and may determine the flexibility of the boundaries needed. Context and individually specific, boundaries in psychotherapy are relative.

Boundaries in psychotherapy

As suggested above, boundaries in psychotherapy are relative to their context, to the therapist and to the therapeutic approach or modality being used (Reber, Allen & Reber, 2009). Boundaries in psychotherapy have a foreboding reputation, described as a 'minefield' or 'slippery slope' (Allan, 2011). Steeped in law and ethics and governed by bodies of authority, boundaries are managed through policies and codes of conduct. Boundaries are informed by a complex network of factors that inform and influence a psychotherapist's decision-making process in all their therapeutic work (Allan, 2011).

Although boundaries are often revered in therapeutic work, they are seldom clearly or unanimously defined in literature (Hermansson, 1997).

Boundaries as a therapeutic framework

Boundaries in psychotherapy are imperative to the process of therapeutic interaction as they offer a framework within which to work. Langs (1988) described the therapeutic frame as providing the 'ground rules' for all interaction in psychotherapy. Boundaries protect both the therapist and the client against harm (Allan, 2011). The therapeutic frame is 'an important tool' for a therapist (Myers, 2000, p. 209). More broadly, it includes the principles and regulations of the therapeutic process and it offers a source of direction and containment or a 'framework' within which a therapeutic relationship can develop and exist (Jenkins, 2005).

Discussing the therapeutic framework, Aravind et al. (2012); Gutheil & Simon (2002); Milton (1993); Mc Williams (2004); and Myers (2000) each refer to the early work of Langs (1982). Each of the authors deliberate and support that the 'frame' functions to uphold the 'ground rules' for all therapeutic interaction. They maintain the notion that the therapeutic frame outlines 'the edge' of appropriate interaction within which the limits of a therapeutic encounter are set and through which the process of therapy can effectively and ethically take place (Aravind et al., 2012, p. 21).

The therapeutic frame allows for an empathic and safe environment for the therapeutic interaction to take place in. Gutheil and Gabbard (1998) describe the therapeutic interaction as "two people talking intimately behind a closed door" (Gutheil & Gabbard, 1998, p. 30). They suggest conceptualising boundaries as a therapeutic frame that acts as "an envelope or membrane around the therapeutic role that defines the characteristics of the therapeutic relationship" (Gabbard & Gutheil, 1993, p. 314).

Boundary-related areas in psychotherapy

When considering the literature on boundaries in psychotherapy, there are several areas around which a boundary difficulty can arise. Gutheil and Gabbard (1998) discuss the

areas in a therapeutic interaction where a boundary related decision is required. To organize and present these areas clearly, headings identified by Gutheil and Gabbard (1998) will be used. They outline several boundary related areas in therapeutic work. They outline the following: (a) Role, (b) Time, (c) Place and Space, (d) Money, (e) Gifts, services, and related matters, (f) Clothing, (g) Language (h) Self disclosure and related matters, and (i) Physical contact (Gutheil & Gabbard, 1998, p. 5).

(a) Role. A therapist's role in the therapeutic relationship is to maintain professional responsibility, establish and maintain confidentiality, and offer a neutral stance and respect for a patient or client's autonomy (Myers, 2000). A therapist's role is to always act in the best interest of the client or patient. The therapeutic role helps to distinguish therapy from other relationships or events in a patient's life (Audet, 2011). Boundaries help to establish clear roles for therapist and client. The trainee psychologist's role *vis-à-vis* the client is multifaceted and depends on the therapeutic approach, context and treatment plan.

The term 'role' is derived from the French word *role,* steeped in early French theatre, referring to the roll of paper upon which an actor's script was written (Reber, et al., 2009). In the Social Sciences, it is a word that refers generally to "any pattern of behaviour that involves the duties, rights and obligations of an individual within a set context and is usually something they are expected or at least encouraged to do" (Reber et al., 2009, p. 691).

Roles may be momentary, such as being 'a winner', or indefinable across time, such as being 'a child, a parent or spouse'. A role may be essentially permanent, such as being 'male or female' (Reber et al., 2009). Similarly, in therapeutic work, roles can be momentary or permanent, or indefinable across time. In the therapeutic work, a psychotherapist's role is a professional one that is relative to the context, person, therapeutic approach, formulation and treatment plan. Professionally, a therapist's role includes establishing and maintaining boundaries, such as providing a safe and comfortable space and facilitating the process of building rapport with a client. Personal fixed roles may be those attributed to the psychotherapist's identity, their race or

gender. Non-fixed roles would include facilitating awareness and the psychological development of a client in relation to their reason for entering therapy (Myers, 2000).

(b) Time. Time in therapeutic work can refer to consultation times, setting a time to meet with clients or patients, the notion of being 'on time' for sessions, as well as the idea of 'keeping time' during sessions (Jenkins, 2005; & Aravind et al., 2012). The notion of time also holds varied connotations in therapeutic work, such as the past, the present and the future (Reber et al., 2009).

Time boundaries occur around boundary-related decisions of how to use or manage time in therapeutic work. Allan (2011) describes time in a therapeutic session as what he calls 'moments' during the therapeutic interaction. Moments such as the beginning, middle and end of a session. He explains that each of these moments pose unique opportunities for boundary related decisions. Focusing on the end of the session, for example, Allan (2011) explains that this "is a moment of vulnerability, amongst other things, a time when some clients may try to extend the time boundary" (Allan, 2011). Gutheil and Simon (as cited in Allan, 2011) identify the moment at the end of a session when a therapist accompanies their client to the door as a time when psychologists often let their therapeutic guard or boundary slip and explain that this is often when boundary crossings are likely to take place.

Decisions around time in therapeutic work are relative to the context and deviations such as missed appointments, switching times, adding more appointments and shortening or lengthening sessions can be considered as boundary transgressions (Chadda & Slonim, 1998).

(c) Place and space. The boundary of place and space refers to where the therapeutic work takes place. It is the designated location of the therapy session (Chadda & Slonim, 1998). This can be either in a consultation room, in an outdoor setting, at an in-patient's bedside or, if needed, at home.

The environment in which therapy takes place often influences the perception and

impact of boundary transgressions. Situational contexts set the climate and both the therapist and client are likely to respond differently in each of these settings (Keith Spiegel, 2008). Different settings are, for example, a formal office setting within a practice, compared to a home office set up in a side room with informal furniture.

For trainee therapists, many boundaries of place and space are not under their control. Trainees often see clients at a time and place that is determined by their training institution and academic schedule (Aravind et al., 2012). Therapy rooms are preset in their layout and shared by all trainees. Offering an already established therapy space allows the trainees to focus on other areas of learning (Chadda & Slonim, 1998). These are boundary related decisions a trainee may take for granted during training and will then face decisions regarding these matters later in their experience as therapists (Chadda & Slonim, 1998).

A therapeutic environment needs to be a consistent and private setting (Myers, 2000). Depending on the context, deviations such as meeting outside the office, making home visits or frequently changing rooms can be considered as boundary transgressions.

(d) Money. Money as a boundary-related matter refers to the business side of therapy. A necessary part of the therapeutic frame is to have a set and unchanging fee (Myers, 2000). In therapeutic work, fees should be kept reasonable for the area and context within which the therapist is working in (Aravind et al., 2012). Consistent collection of payment for therapeutic sessions and charging for missed sessions is considered maintaining a boundary (Chadda & Slonim, 1998). Although dependent on the context (e.g., non-fee paying clinics) in which the therapy takes place, non-fee payment or bartering, reducing fees, accepting tipping, or failing to give a bill, can be considered boundary transgressions.

(e) Gifts, services, & related matters. Boundary matters pertaining to gifts and services rendered in all therapeutic work are placed under careful consideration. The most obvious forms of gifts are consumer goods. There are however, more subtle forms of gift-giving that depend on the intention or goal behind the gift. Such as agreeing to

write a letter for the client if this is beyond the purpose or goal of the therapeutic work. Another example is giving the client a book or offering the client a coffee if this is not a standard practice in the context or setting (Aravind et al., 2012).

As a general 'rule of thumb' both receiving and giving gifts is deemed inappropriate. Relative to the context of therapeutic work, it is generally recommended that a therapist does not accept any gift or token offered, but rather explores the meaning of the item or gesture to maintain appropriate boundaries (Chadda & Slonim, 1998). Distinguishing whether a boundary transgression is a necessary and formulated decision as part of the therapeutic process can be complicated. There are however, context and case specific settings that may arise, where these decisions can be deemed as helpful to the therapeutic process and therefore appropriate. Such as when working with children, if a child draws the therapists a picture, it may be hurtful or rejecting if the therapist does not accept the gift. Cultural contexts are also important, if giving a gift forms a meaningful part of a clients' cultural practice or tradition, accepting the gift may avoid unnecessary complications and keep therapy goals in track. In some circumstances, small, symbolic and therapeutic gifts may be considered appropriate, a token to represent growth or given at the end of therapy, to continue to motivate or encourage the client. When considering the boundary of gifts and services, it is important to keep in mind that it is all relative to the client, context, therapeutic approach and formulation.

(f) Clothing. The choice of clothing a therapist chooses to wear also impacts therapeutic boundaries. For both the therapist and client overtly seductive clothing would be considered a boundary transgression (Chadda & Slonim, 1998). It is suggested that therapists should follow a professional dress code and avoid wearing seductive or revealing attire for work. Professional clothing can help maintain the appropriate professional distance between the therapist and the client or patient (Aravind et al., 2012). Examples of clothing transgressions would be the inappropriate removal of clothing, unkempt or overly casual attire, as well as contextually out of place

attire, being either too formal for the setting, or wearing gym gear, beach wear in a professional therapeutic environment.

(g) Language. Language is a form of communication. It is a dialect that can be verbal or written. In a therapeutic context, the use of language refers to what and how we speak, a medium through which we convey meaning, our feelings, thoughts, ideas and experiences.

Language as a boundary area refers to a therapist's choice of words as well as a therapist's tone of voice used in therapeutic work. The language used should be professional and relatively neutral but not beyond what the client or patient can understand. Abusive, derogatory or double meaning words should be avoided (Aravind et al., 2012).

The use of first names must be carefully considered as this can create a false sense of collegiality. Inappropriate use of words either because of meaning or timing can be considered a transgression (Chadda & Slonim, 1998).

(h) Self disclosure & related matters. Self-disclosure is not a boundary in and of itself, the use of self-disclosure demarcates a boundary in therapeutic work. As a boundary, it refers to the content and purpose of information being shared in the therapeutic relationship (Chadda & Slonim, 1998). When it comes to revealing personal information in therapeutic work, as with other boundary matters, context is key and a relativist approach is necessary. Context is the key determining factor for what kind of disclosure is considered appropriate and what is considered a transgression (Fontaine & Hammond, 1994).

Audet (2011) conceptualises what self-disclosure as a boundary means in therapeutic work in terms of the type of information being shared and its context. Audet (2011) discusses two types of disclosure: immediate and non-immediate disclosure:

> Immediate disclosure is an interpersonal disclosure where the therapist reveals feelings about the client, the therapeutic relationship or an occurrence in

> therapy, non-immediate or intrapersonal disclosure reveals information about the therapist's personal life (Audet, 2011, p. 86).

Considering the above distinction, an immediate disclosure, as part of the therapeutic approach, can be beneficial for the therapeutic process and is part of the therapeutic framework. Although it is a disclosure, in its context, it is not a boundary transgression. A non-immediate disclosure on the other hand, could, depending on the context, client, therapeutic approach and treatment plan, be considered a boundary transgression. This depends on the intention behind the disclosure and the purpose or goal of disclosing at any given point in the therapeutic process. Disclosure should be for the benefit of the client, and not in any way for the benefit of the therapist. Such as if discussing divorce, a therapist shares that they too have experienced or overcome a divorce, to indicate an understanding of the clients' situation, or a level of insight from experience. Non-immediate self-disclosure may lead to overly informal and 'friendly' interaction that is no longer associated with treatment goals (Aravind et al., 2012). Although self-disclosure could either enhance or diminish the perceived credibility and competence of the therapist and the client's role, Audet (2011) finds that therapist disclosure can lead to boundary transgressions. Using the above example of disclosing a shared experience of divorce, it may easily lead to a transgression if the therapy or interaction becomes about the therapist as this no longer meets the client's needs and digresses from treatment goals.

The risk associated with self-disclosure is that it can blur client-therapist boundaries. Self-disclosure decisions should be made consciously and preferably after consultation. Self-disclosure by therapists has often been discouraged (Myers, 2000) because of its potential to distort boundaries, or possibly lead to boundary transgressions that could then undermine the therapist's role and reduce professional qualities.

(i) Physical contact. Boundary issues related to physical contact pertains to the use of the body and touch (Reber et al., 2009). Traditionally, psychology is "a talking profession that does not involve physical contact" (Allan, 2011, p. 185). Psychotherapists need to be conscious and careful about all decisions to touch a client. It is generally accepted that "handshakes and occasional 'pats on the shoulder',"

(Applebaum & Gutheil, 2007, p. 143), relative to the context in which they occur, are the limit of acceptable physical touch (Allan, 2011; Chadda & Slonim, 1998; Gutheil & Gabbard, 1998; Myers, 2000; Reber et al., 2009).

A hug in a therapeutic environment could be considered a boundary transgression (Myers, 2000). Some boundary transgressions may be benign in intent but harmful in effect (Gutheil & Gabbard, 1998). Hugging could be received badly by the client or patient depending on the person, context and case. For example, a client with a history of sexual abuse, could find the touch or physical contact (e.g. a hug) offensive or an intrusion of their personal space (Allan, 2011).

A therapist may encounter an unanticipated scenario such as a client impulsively kissing or hugging the therapist or "disrobing" in front of the therapist. The client's unexpected behaviour could pose a threat to the professional boundaries, however, whether it leads to a transgression depends on the therapist's response (Gutheil & Gabbard, 1998).

As with other boundaries in therapeutic work, the boundary of physical contact is relative to situation, context, therapeutic approach and formulation. For example, when working with children, boundary decisions around physical contact such as hugging, as a means of greeting or a way of consoling an upset child without being rejecting or hurtful. Culture is also an important aspect to consider. For example, Smith and Fitzpatrick (as cited in Allan, 2011) explain that in some cultures such as in French culture, it is customary and widely accepted to hug and kiss on both cheeks. Despite physical touch being a controversial issue with no consensus, it is generally agreed to be a high-risk activity and a minimalist approach is recommended (Allan, 2011; Chadda & Slonim, 1998).

Boundary-related decisions in psychotherapy

Boundary decisions require an understanding of what boundaries are and how they function in therapeutic work. Glass (2003) explains that it is essential to differentiate

between a boundary crossing and a boundary violation. Gutheil and Simon (2002) distinguish between a boundary crossing and a boundary violation. They define a boundary crossing as "a deviation from traditional psychotherapy that neither harms or exploits the patient and may even advance the therapy process" (Gutheil & Simon, 2002, p. 29). A boundary violation is usually exploitative and harmful in nature and serves to benefit the therapist and not the therapeutic process and is likely to cause harm to the patient (Gutheil & Gabbard, 1998).

The decision-making process involves identifying, establishing and maintaining boundaries as well as repairing boundary-related transgressions, and understanding the difference between a boundary crossing and a boundary violation. Glass (2003) speaks about a 'grey area', a spectrum of boundary related decisions. It is often difficult to tell a boundary violation and a boundary crossings apart. As Martin, Godfrey, Meekums & Madill (2011) explain, it is relative. Psychological, situational and relational elements of the therapeutic relationship each play a fundamental role in determining and understanding this 'grey area'.

Gutheil and Gabbard (1998) recommend avoiding a fixed rules approach, or the do's and don'ts of therapeutic practice. What they call the "list of generically forbidden behaviour" (Gutheil & Gabbard, 1998, p. 409). They explain that these offer a false sense of clarity. They recommend the best way to remove any uncertainty about a boundary decision in therapeutic work is through clear and concise documentation in clinical notes, such as in the form of process and or progress notes. Apart from being a legal and ethical responsibility, record keeping is useful to show evidence of the therapist's management process. It encourages reflective and transparent practice, reducing the risk of boundary transgressions.

A boundary transgression is a deviation from the identified and agreed upon therapeutic frame. A boundary transgression is essentially determined and influenced by the context in which it occurs. Some transgressions are necessary, some helpful, and others not (Glass, 2003).

Theoretical Orientation

Theoretical orientation influences how a boundary is viewed and used. It determines whether a boundary transgression would be considered as either a boundary crossing or boundary violation. For example, from a behavioural therapy perspective, such as in vivo exposure therapy, boundaries of time and place are considered negotiable. A deviation if mutually agreed upon, would not necessarily be a boundary transgression. In psychodynamic therapy, on the other hand, boundaries of time and place are held more constant (Kazi & Indernum, 2014) and a deviation could be considered as a boundary transgression. A psychodynamic perspective views the frame as essential to the therapeutic process and views it necessary to protect the frame from any sort of intrusion from the external world (Kazi & Indernum, 2014). Boundaries as well as boundary transgressions are also explored within the therapeutic process and believed to be necessary for therapeutic change and growth to occur. Boundaries are viewed and used as "a crucial container for facilitating the process of client change" (Jenkins, 2005, p. 42).

Managing boundaries

How strictly to adhere to boundaries is often the topic of hot debate, with traditional views being more rigid and modern approaches being more flexible (Allan, 2011; Bridges, 1999; Gutheil & Gabbard, 1998). Despite there being no consensus on the degree to which to adhere to boundaries, it is agreed that boundaries are both fundamental and essential to all approaches and as such, boundary decisions should "be guided by the existing guidelines that reflect the accumulated and collective wisdom of psychologists" (Allan, 2011, p. 174).

Therapists making boundary decisions should assume the role and responsibility to be aware of, and anticipate, possible boundary concerns or difficulties to address them in advance (Allan, 2011).

Martin et al. (2011) warn that when no immediate disaster or threat is experienced after crossing a boundary, the therapist may begin to feel that other boundary crossings will be just as safe. The therapist then develops a false sense of security that can lead to the

perilous slide down the 'slippery slope' (Allan, 2011). Gutheil and Gabbard (1998) recommend three approaches for handling any boundary crossing or possible violations; (a) maintain professionalism (b) provide debriefing and (c) document the process.

When making boundary related decisions, the ethical principles that regulate the practice of psychotherapists need to be kept in mind. In South Africa, therapists refer to the Ethical Code of Professional Conduct of the South African Psychologist Board (2002). This code serves as an example of a code of a regulatory body (Allan, 2011). The ethical principles found in the code of conduct literature are those of:

> "(a) Autonomy (right to make own decisions), (b) according dignity (treat as worthy of respect), (c) non-maleficence (do no harm), (d) beneficence (do good), (e) justice (be fair/treat equally), (f) veracity (obligation of truthfulness), (g) fidelity (common decency), (h) care and compassion (considerate and kind), (i) responsibility (accepting accountability) and (j) competence (pursuit of excellence)" (Allan, 2011, p. 112).

The decision-making process around boundaries in psychotherapy needs to be made with these principles in mind. In this way, the risk of boundary transgressions is minimised or avoided. Boundary difficulties arise from this decision-making process, managing and negotiating boundaries in therapeutic work.

Boundary-related difficulties in psychotherapy

Various boundary difficulties in psychotherapy exist, including boundary maintenance issues, boundary risk management, boundary ruptures, managing boundary crossings and repairing boundary violations. Discussion about boundary-related difficulties most often occur within an ethical and legislative context and the focus of these discussions is often in relation to sexual misconduct (Allan, 2011; Bridges, 1999; Milton, 1993; Pope & Spiegel, 2008; Simon, 2011). As discussed earlier, boundary-related difficulties around the areas of role, time, place and space etc., can also occur in all areas of therapeutic work (Gutheil & Gabbard, 1998).

Phillips (as cited in Urdang, 2010) explains that psychotherapists can inadvertently find

themselves in compromising situations. The decision-making process around concerns about feelings of closeness to clients and being uncertain of how to deal with these feelings are examples of boundary related difficulties (Howard, Inman & Altman, 2006). These are often referred to as non-sexual boundary-related difficulties. And incorrectly handled can lead to a transgression such as over involvement or a dual relationship with a client or patient.

The discussion about boundary related difficulties in psychotherapy are not specific to trainees, but apply to all psychotherapists (Norris, Gutheil & Strasburger, 2003). For trainees, however, boundary difficulties are potentially significant learning moments in therapeutic work. They provide opportunities for learning how to establish and maintain appropriate and effective boundaries through the experience of the decision-making process. Without such experience, boundary transgressions such as emotional over involvement and sexual misconduct can occur (Urdang, 2010). Bhola et al. (2015) remind us that as much as boundaries are a part of all therapeutic work, important to all therapists alike, "these complexities and challenges may be magnified during the training phase" (Bhola et al., 2015, p. 1).

Urdang (2010) distinguishes impaired professionals from what she refers to as normative violators. She describes trainee psychologists as being normative boundary violators, who are just naïve, inexperienced or inadequately trained (Urdang, 2010). Normative boundary problems experienced by trainees occur frequently and are a function of their development as psychotherapists, as well as a part of the distinct demands and pressures of professional training (Skovholt & Ronnestad, 2003).

Trainee-specific boundary difficulties in psychotherapy

Boundary difficulties occur all the time, but given a trainee's lack of experience, it is important to engage in a conversation about boundaries and the process of negotiating boundary difficulties (Allan, 2011; Audet, 2011; Bridges, 1999). Trainee psychologists early in their training are known to experience self-doubt and uncertainty regarding their readiness for the task of being therapists. Because of the self-doubt and uncertainty, experiencing difficulties regarding boundaries in therapeutic work is not uncommon (Hill et al., 2007; Skovholt & Ronnestad, 2003; Urdang, 2010).

Hermansson (1997) explains that a common trainee boundary-related difficulty is to do with managing roles. Navigating the complexities and challenges of "shifting from the known role of lay helper to the unknown role of the professional" (Bhola et al., 2015, p. 2).

Exploring trainee specific difficulties provides an understanding of their experience in the decision-making process. It also offers an opportunity for the difficulties to be addressed and in turn, guides the development of trainees' skills in the boundary-related decision-making process in therapeutic work. Initiating a conversation about trainee boundary difficulties early in training creates an awareness, can provide practical solutions and can also prevent boundary transgressions in the future (Audet, 2011). Learning through the experience of boundary related difficulties in psychotherapy is a fundamental part of the development of the trainee therapist as it transitions the trainee from theoretical and classroom-based therapeutic skills to the working professional self (Urdang, 2010).

Summary

Boundaries in psychotherapy are important for both the therapist and the client as they outline and determine interaction that is ethically acceptable in therapeutic work. Understanding what boundaries are and how they serve therapeutic work is important for all therapists (Audet, 2011; Allan, 2011; Aravind, et al., 2012; Gutheil & Gabbard, 1998). Boundaries form the therapeutic framework and how they are managed impacts on the therapeutic relationship and potential outcome (Audet, 2011; Allan, 2011; Aravind, et al., 2012; Bridges, 1999; De Sousa, 2012; Jenkins, 2005; Myers, 2000; Pope & Spiegel, 2008). All therapists face boundary related decisions and difficulties in their therapeutic work. Trainees' experience of these interactions and decision-making opportunities are part of the developmental process of becoming a psychotherapist (Bhola, et al., 2015; Hill, et al., 2007; Skovholt & Ronnestad, 2003; Urdang, 2010). For trainee psychologists, as part of their development and training, even just a conversation about boundaries and boundary-related difficulties supports and facilitates their development as psychotherapists (Urdang, 2010).

Research on the development of trainee psychotherapists has focused on critical incidents that involve trainees developing a secure sense of self, navigating the first interview, concerns about taking on the psychotherapist role, difficulties related to clients not meeting expectations, the helpful nature of supervision, and self-reflection. Trainees are described as often being overwhelmed by the cognitive demands as well as by the personal nature of therapeutic work (Hill et al., 2007; Hiebert, Uhlemann, Marshall & Lee, 1998; Johnson & Heppner, 1989; Skovholt & Ronnestad, 2003; Urdang, 2010). Zeddies (1999) describes that '[M]any voices clamour for attention in a [trainee] therapist's head… and in the development from student to seasoned clinician, a therapist learns to become a better listener to both himself and to clients' (Zeddies, 1999, p. 234).

Although extensive research has been conducted on the development of trainees and trainee difficulties related to the process of becoming a psychotherapist, there is limited research on trainees' experiences of boundary difficulties (Bhola et al., 2015). The trainee difficulties identified earlier, self-doubt, anxiety, etc., makes trainees particularly vulnerable to boundary related difficulties. Being a trainee, inexperience brings with it difficulties related to making decisions around boundary-related areas during interactions with clients or patients. It also brings with it challenges of feeling troubled by moral or ethical issues (Bhola et al., 2015).

Bhola, et al. (2015) advocate for the need to explore boundary difficulties experienced in the early phase of professional development. It is especially important to understand the boundary difficulties that trainee psychotherapists experience early in their development as professionals as this is where boundary management begins (Hermansson, 1997).

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter outlines the methodological approach used in this study. It presents the research design and rationale. It briefly outlines the approach used and discusses the processes of sampling, data collection and data analysis. The chapter also presents the ethical considerations and procedural rigour.

Research Design

A non-experimental, qualitative, multiple case study design, was used in this study. Qualitative research has its roots in the paradigm of phenomenology and is concerned with understanding experience (Willig, 2008). It is an approach to research concerned with 'how people gain knowledge of the world' by asking "how" questions and using an insider's view for an understanding of experience (Pietkiewicz & Smith, 2012, p. 361).

A qualitative methodology is a naturalistic approach that considers contextual detail such as where the research takes place and the characteristics of those whom the research involves. It uses an inductive process for understanding data and it works with a small sample group, focusing on the depth of the data. This approach allows for the collection of rich data and analysis, which facilitates detailed descriptions of experience (Babbie & Mouton, 2004). This research study recognised that qualitative research is not an objective process (Willig, 2008). It also considered the subjective involvement of the researcher, where the researcher uses the data to try and grasp the experiences of trainees' boundary difficulties to offer insight into how trainees in their given context, make sense of these.

Interpretative Phenomenological Analysis (IPA) is an approach to qualitative research concerned with making sense of how phenomena are experienced (Pietkiewicz & Smith, 2012). With an idiographic focus, it aims to offer insights into how a given person or group, like trainee psychotherapists, make sense of a certain phenomenon such as boundary difficulties in psychotherapy. Concerned with understanding

experience and making sense of the meaning it holds through interpretation, IPA assumes a hermeneutic stance (Pietkiewicz & Smith, 2012).

An alternative methodological approach was considered, namely a Grounded Theory approach (Babbie & Mouton, 2004). This approach would have explored trainee boundary difficulties and made sense of the data by inductively creating codes, concepts and categories to derive a conceptualisation or theory of trainee boundary difficulties. However, as the focus of this study was to explore the experiences of trainees' boundary difficulties, a grounded theory approach was not considered appropriate.

Methodological approach

A methodological approach was used in this study in order to explore trainee psychologists' experiences, and thus to understand from their perspective, their boundary difficulties in therapeutic work. The aim was to present the experience of boundary difficulties as accurately as possible, with an idiographic focus and procedural rigour, and to capture the essence of the trainees' experiences through the researcher's interpretations.

This approach does not seek to provide factual accounts, but rather uses the rich data to offer an interpretation of the boundary difficulties trainee psychologists experience. The study implements a double hermeneutic (Pietkiewicz & Smith, 2012), in that by adding an interpretive dimension in the analysis of the data, it offers an opportunity for the trainee psychologist's inquiry and meaning-making to be interpreted by the researcher.

Participant Selection

In line with qualitative research and an IPA approach, a small sample was used for this study (Pietkiewicz & Smith, 2012; Willig, 2008). Seven participants volunteered to take part in the study and formed the sample group. Polio and Thompson (1997) identified the appropriate sample size of three to five transcripts for thematic patterns

to emerge from interview data. Therefore, the study aimed to engage with a minimum of five participants for the interviews.

This research study was specifically interested in trainee psychotherapists. The study was conducted at a university and focused on trainee psychotherapists in their Masters year of training. A method of purposive homogenous sampling was used for selecting participants at whom the research question was directed. A homogenous sample is one that is alike (Pietkiewicz & Smith, 2012; Willig, 2008). The homogeneity of this sample was defined based on participants' level of professional development.

The sample are psychology students in their Masters (M1) year of training. Students at this point have completed a minimum requirement of an honours level of training in psychology. The sample consisted of both clinical and counselling students. The students were at the end of their Masters year of training, each having had the opportunity to work one on one with clients in a clinical setting and under supervision.

Data Collection

The research study obtained full ethical approval before the data collection commenced. Permission was granted by the Registrar of the University of Kwa-Zulu Natal, the Research Ethics Committee as well as by the Academic Co-ordinator of the Masters training programme. Requests to participate in the research study were sent out to the clinical and counselling Masters students at the time. Before data was collected, participants were fully informed of the research procedure and understood all the processes involved (See consent form in Appendix).

Semi-structured interviews were used to collect data from the research participants. The interviews were conducted by the researcher and participants were interviewed once. Interviews were done only when a signed informed consent to participate and a signed audio recording consent form was completed. The interviews were audio recorded and each lasted approximately forty to fifty minutes.

Semi-structured interviews are commonly used for a flexible, open-ended inquiry, allowing for richness and depth of data. They offered an opportunity for an open-ended conversation and the development of a narrative of experience (Willig, 2008).

The interviews were scheduled with students who volunteered to participate and took place over a two-week period. Interviews took place at the end of the students' academic training programme and participants were asked to reflect on their experiences of boundary difficulties in their therapeutic work.

The semi-structured interviews included open-ended questions covering the following broad topics: "How did you experience working with boundaries in your therapeutic work?"; "What types of boundary difficulties did you experience in your therapeutic work?"; "How did the boundary difficulties influence or impact your therapeutic work?"; "How would you describe your experience of boundary difficulties in your therapeutic work?"; and "How did you manage the boundary difficulties?". The semi-structured interview was used flexibly and additional prompts were used as necessary. Paraphrasing and summarising were done using the participants' own vocabulary where possible.

A single pilot interview was conducted. The pilot interview identified the importance of prompts, paraphrasing and clarifying the conversation. For example, asking what types of strategies participants used to manage boundary difficulties helped to expand the conversation from simply stating or reporting specific incidents to a conversation about internal and external resources. There were no changes to the major questions outlined in the initial interview schedule, only the addition of prompts used to open topics of conversation. The pilot data was not included in the final analysis.

The data collection was a flexible and open-ended inquiry that yielded rich data in the form of detailed interview transcripts. They were later transcribed verbatim from an audio recording of each interview. This provided a rich narrative of experience to be used for the data analysis.

Data analysis

The research data in this study was understood to be the verbal expressions of the trainee psychologists' meaning-making process of their experiences of boundary difficulties in psychotherapy (Polkinghorne, 2005). The data analysis procedure explored key areas of meaning for the trainee psychotherapists (Willig, 2008).

The research design allowed for the exploration and understanding of the trainees' experiences both as individuals as well as, as a group.

Interpretative Phenomenological Analysis

The interview transcripts were analysed and interpreted using the IPA method (Pietkiewicz & Smith, 2012; Willig, 2008). IPA is an idiographic approach aimed at understanding how the trainees made sense of and gave meaning to their experiences of boundary difficulties in psychotherapy (Pietkiewicz & Smith, 2012). This method of analysis provided insights into the real-life world of participants' subjective experiences of boundary difficulties in psychotherapy (Leech & Onwuegbuzie, 2007).

The following methodological process was followed as per Pietkiewicz & Smith (2012) who recommend:

(a) Immersion and familiarisation with the context and data, which included reading transcripts and listening to audio recordings several times.
(b) Making unfocused notes which reflected initial thoughts, observations and comments (phenomenological coding).
(c) Themes identified and ascribed to sections of text, to explore each transcript for meaning, done per individual participant (master themes).
(d) Attention to patterns, contradictions, metaphors and imagery (interpretative coding).
(e) Grouped themes to reflect wider concepts and shared meanings (superordinate themes) that applied to all participants and represented their individual experiences.

(e) Produced summary tables of emergent themes and superordinate and subordinate themes (Pietkiewicz & Smith, 2012).

After transcription, the researcher read and re-read the transcripts to become familiar with the data. The researcher also listened to the audio recordings several times to help with immersion in the data. It also allowed the researcher to make reflective notes about the atmosphere in the room and the setting. The researcher focused on the content of the audio recordings, the language used, context and initial interpretative comments (Pietkiewicz & Smith, 2012; Willig, 2008).

The researcher made unfocused notes and exploratory comments to reflect initial thoughts and note descriptive, conceptual and linguistic aspects of the narrative (Pietkiewicz & Smith, 2012). Following this, the researcher then identified and labelled emergent transcript themes as recommended by Pietkiewicz and Smith (2012). These reflected both the participants' remarks and the interpretation of the researcher.

Emergent themes were determined by several aspects, such as how often a topic or area of interest was mentioned or how intensely a participant felt about it. They were then grouped and organised into possible superordinate themes (Pietkiewicz & Smith, 2012). A summary table was drawn up with a representation for each participant. Themes from all transcripts were compared and grouped to form a final list of superordinate themes which conveyed and represented the researcher's interpretation of the participant's experience (Pietkiewicz & Smith, 2012).

Reflexivity

An imperative part of any qualitative research study is the notion and practice of reflexivity (Shaw, 2010). For this study reflexivity was defined as "an explicit evaluation of the self" (Shaw, 2010, p.234). This was an organised and fundamental activity practiced by the researcher throughout the research process. This is different to reflection, which is important, but not necessarily embedded in the research design (Shaw, 2010). Embedding reflexivity into the design of the research study provided methodological rigour (Parker, 2005).

The study considered the researcher's role and influence in the process of making meaning and interpreting the trainees' experiences. The researcher maintained the responsibility of keeping a reflexive stance throughout the research process by way of a reflexive journal (Shaw, 2010). The reflexive journal was used to make notes of observations and comments, considering the research context, trainee psychologists' culture and the relationship characteristics between the researcher and the participants (Morrow, 2005). The researcher kept track of any bias and assumptions, whilst making sense of how participants understood boundary difficulties.

As the researcher, I was conscious and aware of my background. I was previously an M1 student, in the year prior to conducting the studies data collection. Prior to my training year, I had little experience of boundary-related decisions or difficulties in psychotherapy. During my M1 training, it was strongly recommended that as trainees we all commence our own therapy. This in part was to offer support and in part to learn and gain an understanding of what it is like to be a client. During this experience, I found myself most interested in the way I as a client, understood and treated the boundaries of the therapeutic relationship. I learnt from the experience that for both the client and a therapist, boundaries have a value and that when understood and respected can offer richness to the therapeutic experience.

As a researcher, I was aware of my own bias towards boundaries, boundaries of time for example, and how in my own experience as a client in therapy, time offered a certain 'holding' for me. Self-disclosure was another bias I was aware of from my experience as a trainee therapist. Throughout the research process, I was aware of these as my own experiences, especially when making sense of how the participants handled boundaries.

Ensuring trustworthiness

Safeguarding the procedural rigour of the research, the study addressed the areas of credibility, dependability, transferability and confirmability (Babbie & Mouton, 2004; Shenton, 2004).

The study made efforts to ensure its trustworthiness and achieve credibility by using a well-established research method. It followed the procedural steps of the method, such

as familiarisation and immersion of data, to accurately represent the experience of participants. It was committed to making sense of the trainees' subjective experiences by working closely and intensively with the data. In this way, it achieved Morrow's (2005) standard of immersion deemed necessary for the interpretation of data. The study also made efforts to achieve credibility by using only voluntary participants who were genuinely willing to take part (and thus were more likely to be honest and authentic in their responses to interview questions).

The study's dependability was achieved by its operational details. It had a clear research design to follow and guide the process. It had a clearly outlined procedure for data collection and data analysis enabling future researchers to repeat the process, using the design as a prototype (Shenton, 2004).

In terms of transferability, the study was mindful to disclose contextual detail such as where the study was based and information about the sample group. It recognised that the experiences and interpretations were influenced by the specific individuals, instructors and curriculum for that year. By giving a detailed account of the design and methodology, the study aimed to be transparent in its approach. It used verbatim transcripts and provided direct quotes to represent and highlight key areas of participants' experience. It remained aware of the researcher's influence, and the researcher kept a reflexive journal to note and identify underlying assumptions.

The research context, coupled with the research methodology, provides the extent to which the reader can transfer its findings into his or her own context (Holloway, 1997; Shenton, 2004). Phenomenological research by its very nature, does not allow for easy repetition of findings, as it aims to capture idiosyncratic experiences that are context specific (Morrow, 2005). Rather than aiming to achieve generalizability, the intent was to generate a rich and deeper understanding of a specific group's experience (Leech, & Onwuegbuzie, 2007). Although the findings are not generalizable to other groups of trainee psychologists, they are nonetheless informative about this specific group. The findings can also potentially guide and inform similar contexts or settings, such as similar training programmes and help inform other trainees in their development as psychotherapists.

Ethical Considerations

Ethical concerns in this study were informed consent, confidentiality and the anonymity of participants. The study carefully considered the participants' consent to participate and the confidentiality of the information they shared. The study recognized that the research took place within the department within which the students were enrolled and that this meant there was a limit on confidentiality, in that the findings and interpretations were specific to the group of trainees in that current year of study. Conscious effort was thus made to ensure the anonymity of participants within the department and university.

Research participant accounts of boundary difficulties had the potential to bring forward unethical conduct. The researcher addressed this by making clear before the interview, that the study was not interested in noting incidents of unethical practice, such as sexual misconduct. Instead it was interested in understanding the experience of boundary difficulties and transgressions in the therapeutic process (Glass, 2003). Participants were also assured that any boundary difficulties or transgressions, experienced in their therapeutic work, brought forward or identified by the research, would in no way affect their performance appraisal for their training programme. Participants were made aware of referral routes and options for support if they felt the need to debrief about issues raised in the interviews.

The research study also recognised its ethical responsibility to the trainee psychologists' clients as the participants were asked to reflect on casework and discuss experiences they had had with clients. Though not specifically discussing client or case information, the researcher nonetheless ensured that trainee psychologists had signed the Applied Psychology Clinic's contract with their clients within which the client acknowledged and consented for the trainee psychologist to use the data from their therapy session for training and research purposes.

CHAPTER FOUR

FINDINGS

This chapter discusses participants' experiences of boundary difficulties in psychotherapy. It presents themes that were identified through the process of IPA. Thirteen emergent themes were derived from the data analysis (See Table 1). These informed the advent of five superordinate themes, each with subordinate themes that represent the essence of the emergent theme (See Table 2). In line with the qualitative and IPA research methodology, this chapter includes a reflective summary of experience for each participant and the researcher's reflections on the data analysis process.

Areas of difficulty that emerged

A process of identifying and labelling emergent transcript themes was used to make sense of the participants' experiences. This process was informed by an idiographic approach and involved exploring each participant's audio recording and transcript individually, before making general comments or observations (Pietkiewicz & Smith, 2012).

Transcript themes were derived from the researcher's exploratory notes and observations of the data, including descriptive, linguistic and conceptual aspects (Pietkiewicz & Smith, 2012). The themes reflect participants' commentaries and the researcher's interpretation of both overt and implicit meaning that had relevance to the participants' experience.

The areas of difficulty are presented below. They are later discussed under the superordinate theme headings. By way of organising the themes, they were clustered according to the number of participants having mentioned them. The table displays a group overview and highlights some common and infrequent features of boundary related difficulties.

Table 1. Areas where boundary difficulty were noted

Participants	Areas where boundary difficulty were noted	P1	P2	P3	P4	P5	P6	P7
ALL	Professional role	▪	▪	▪	▪	▪	▪	▪
	Space/Environment	▪	▪	▪	▪	▪	▪	▪
	Physical contact	▪	▪	▪	▪	▪	▪	▪
	Working with children	▪	▪	▪	▪	▪	▪	▪
	Finding supervision helpful	▪	▪	▪	▪	▪	▪	▪
MOST	Managing time		▪	▪	▪	▪	▪	▪
	Gifts	▪	▪	▪	▪	▪		▪
	Self-disclosure	▪		▪	▪	▪	▪	▪
SOME	Use of language	▪	▪		▪	▪	▪	
	Trainee anxiety	▪		▪		▪	▪	▪
	Feelings evoked	▪	▪			▪	▪	▪
	Reflective practice			▪	▪	▪	▪	▪
FEW	Choice of clothing	▪	▪					

A reflective summary of the researcher and each participant's experience

The following is a reflective summary of the researcher and each participant's experience. A description of who the participants are is provided to offer the reader contextual information and outlines the participants' general opinions and attitudes towards boundary difficulties in psychotherapy. Although participants are referred to as participant 1, participant 2, etc., the participant accounts were randomised to ensure the anonymity and confidentiality of the participants.

As a researcher, I had an active role in the research process. As part of the research design, I kept a reflective journal. With this journal, I carried out an activity of "Bracketing" (Pietkiewicz & Smith, 2012, p.362) where I noted my assumptions and preconceptions, before starting the data collection process. I kept these in mind as I worked closely with the data, to allow the phenomena to speak for itself, without my

own bias or preconceptions influencing how I understood or interpreted the data. My reflective accounts and comments on the data collection and analysis process informed the emergent transcript themes and superordinate themes.

Who I am as researcher was recognised. I was recently a trainee psychotherapist myself and this allowed me as a researcher, to understand and comprehend the context within which the research was taking place. It offered an opportunity for insight into the mind-set of 'trainee' participants. I felt that it facilitated how I understood the participant's experiences, allowing me as a researcher to attempt "to stand in the shoes" (Pietkiewicz & Smith, 2012, p.362) of the participants and at the same time recognise that this was never completely possible.

Whilst listening to audio recordings and re-reading transcripts, during which I made note of distinct phrases and emotional responses, I identified and clustered descriptive words used by the participants specifically to describe their feelings related to boundary difficulties. I understood these as a representation of the participants' feelings experienced whilst working through boundary difficulties in psychotherapy. I found that the feelings moved across a spectrum from an initial experience of fear in anticipation of possible boundary difficulties, using descriptive words such as 'panic'; 'worry'; and 'dread', to an experience of confusion in the decision-making process, characterised by feelings of being 'unsettled' and 'unprepared'. I understood that participants at the end of the spectrum identified feeling secure and validated, mostly through the support from supervision and their reflective practice. Participants ultimately reflected on their experience of boundary difficulties as having been a difficult but productive one.

Participant one (P1)

P1 was a Masters student, who was at the end of her one-year training programme. She explained having really struggled with the 'unwritten' nature of boundaries (Theme (1a) that will be discussed later). She described feeling unsettled, explaining that "sometimes you don't know if what you are doing is proper or if what you are doing is like umm, off". P1 described the experience as being "like in limbo sometimes" because she is normally very prepared, and used to following instructions. The participant

described herself as feeling "like an empty vessel". I didn't initially pick up on this remark, only after listening to the audio recordings again, and having re-read the transcripts, whilst reflecting on their experience, I found myself wondering if even with all the theory, all the guidelines, having to let go of the structure and be 'an empty vessel', is what was a necessary part of the experience of boundary difficulty. For example, as captured in theme (5) learning from the experience, (5a) self-awareness and reflective practice.

I found myself wondering if feeling 'terrible' and 'guilty', is a necessary part of the learning experience (theme (4e) feelings evoked, to be discussed later). Does working through these difficult feelings move the participant to an informed or experienced level? She explained: "I found it difficult to reconcile in my own mind" a decision she had made to not give a child client something they had asked for. This is discussed further under theme (5) learning from the experience and the role of (5b) supervision.

Participants seem to get to a point after reflecting, where they feel okay to make mistakes, and feel okay to sit with the "grey" nature of boundaries, and trust the process. P1 explained "we as people are work in progress, we won't be perfect, no one is perfect". P1 was very open to sharing her experiences of boundary difficulties, I found that I hardly probed. I felt grateful for the forthcoming nature of her responses, as it was my first interview, and I was feeling anxious myself.

As this was my first interview, I was intent on capturing as full an account of P1's experience. At times, I needed to decide when to probe or not, and when to stay on topic or move on. This was a fine balance throughout. I wondered how my own desire to understand as much as possible impacted my ability to listen. And how who I am as the researcher impacted how easily we established rapport.

Participant two (P2)

Prior to our meeting P2 had introduced herself as a student and a mother, and in setting up our interview appointment, it became apparent that we had a shared experience of 'motherhood'. P2 would say things like "you know what's it like, as a mother you kind of just learn to say no". I found it was worth considering the impact of this, to

understand, was there an element about myself as the researcher that was disclosed when setting up the interview, that may have contributed to the ease with which rapport was established and the openness with which the participant shared and reflected on their experience.

Different to P1, who seemed self-focused, P2 had a particularly intense awareness of a sense of responsibility not to do any harm. She explained, "it was difficult for me, it was difficult to draw that boundary, it was difficult to be effective, to be caring, umm, and not rejecting". During the interview with P2, as she openly reflected on her experience, I sensed a kind of 'existential crisis', wondering how to balance being a person and a professional.

Similarly, to P1, P2 made a comment reflecting an understanding that although apprehensive, there is a need to experience difficult moments and learn from them. P2 understood it as "a process, like, I've just got to do this". Also, like P1, P2 reflected on the fact that as trainees, they looked for structure, a guide, a tool kit or a plan of action, that they hoped would make the difficult moments easier to handle, or avoid, "I think I need to come up with a few key phrases, so like a strategy". "I suppose it's just experience, umm, living in regret. So, you learn things, but until you experience them you don't realise the relevance".

I noted an initial thought during the interview process in my reflective journal, wondering how I would have identified boundaries in psychotherapy and how I would have described them in my previous year of study when I was an M1 student. The researcher's experience of making sense of the participants making sense of boundaries in psychotherapy prompted a thought, Was this seemingly inherent sense of foreboding specific to trainees or would it remain across the span of development? P2: "I definitely think the entire view of a boundary issue is completely different when you get here and again by the end of the year… you sit in the room with the client and go ok, so this is what it is". I reflected and wondered if my view of a boundary issue was different now to before my training. The foreboding features of working with boundaries are captured in theme (4b), who the therapist is as a person, and will be discussed shortly.

Participant three (P3)

Rapport was easily established with P3. In the moments before the interview started, P3 mentioned that she was happy to participate, explaining "as a masters' student I understand, you need participants". P3 seemed to really think before responding and appeared to be comfortable and honest in exploring her difficulties. This participant was the only one who commented on the fact that the room we (the researcher and participant) sat in was the same room that she (the participant) saw her clients in. P3 explained that "sometimes it's like, you are constantly kind of worrying, am I doing it right?... it was difficult, I was very confused about what to allow or not… the whole time I was like, I don't know if I was allowed to do that". P3 shared the same sentiment as other participants, that being faced with a situation that required a difficult decision, whether making the right or wrong decision at the time, they had to make a call, and could learn from it, even if it was only in hindsight.

Following the interview P3 mentioned doing research herself, and understood how hard it can be to get participants to volunteer, and said that she hoped that her interview would yield rich enough data for my analysis. P3 seemed to find reassurance in making difficult decisions. "It was hard, coz it's such a hard process itself, it was like, as long as we are not doing anything wrong." P3's psychodynamic training came through, in how she made sense of her experience of the boundary difficulty, explaining that "when I would feel frustrated or angry, I had to hold this sense of not being in control, powerless, chaotic", and then after understanding the transference and countertransference, find it revealing and informative for the therapeutic process.

Participant four (P4)

P4 had clearly prepared before the interview. She used terminology like ethical practice, professional practice, boundary crossings and boundary violations. The interview initially felt stilted, and I found myself wondering how prepared or authentic this participant's responses were. I found that with P4 I would often have to ask her to elaborate. P4 reflected on a case with a child, and commented: "I think that was the difficult moment, trying to figure out when was the right, or perfect time to reach out to the child". "Do I get closer? Do I touch, but I made the decision to move closer and that was what made the whole session, umm, productive." After sharing that, P3 reflected for a moment, and I remember wondering if I should stay in the moment too,

and not move on. P3 broke the silent moment exclaiming “it was hard, it was so hard”. Although being a more formal interview, the participant and I were able to engage and establish rapport, and P3, like the other participants, used the interview as opportunity to reflect upon and explore her experience of boundary difficulties. “It’s scary as a student, because you’re like, am I doing the right thing or not, because you don’t want to find out it’s a not afterwards (nervous laugh) … cause in that moment you don’t feel like you are qualified enough to do clinical judgements like that.” P3 explained that “boundaries go beyond just the clinical setting you know, the supervisor, your personal self”. I thought this was such a profound statement, and found myself again wondering if the participants themselves, realise or are aware of how much meaning is there. I found this statement informed how I organised the superordinate themes, trying to also go beyond the clinical setting and highlight the participants’ experience of supervision in relation to boundary difficulties.

Participant five (P5)

P5 had prior experience working with children and seemed to relate much of her understanding of boundaries and boundary difficulties to these experiences. I found myself working hard to stay on topic, and wondering how to stay focused on reflecting on the master’s year only. This was the only participant who identified some boundary difficulties that were experienced outside of the master’s training year. P5 reflected on a case where she experienced a difficulty being clear about her role as a therapist, particularly because she had previously played a different role, and remembered “it was very strange, I was so nervous, my body language was so weird, my voice was so weird…” and then realising that “some of the same rules apply, without feeling panicked that I am doing the wrong thing”. She explained that “there were lots of things I anticipated as being very difficult, and now coming through this year I feel more competent and a lot more relaxed about the process… but I guess that negotiating those different boundary has contributed to that”.

Participant six (P6)

I found that this interview seemed to last longer than it did. I wondered at times… I noticed that this participant found it difficult to elaborate on her answers. This participant was very guarded and I really had to probe. I wasn’t sure how much of it

was a reluctance to share or her sparse memory of the case work. She explained "that's the hard part, when do the boundaries have to stay and when can you, when is it okay to lapse them a little… and then you are stuck wondering". P6 also explained that "boundaries are there, they should be there, but there are times when it's okay to cross them because it doesn't do harm to you or your client".

Toward the end of our interview, P6 shared a thought:

> "I think as the years go on you will be able to tell the difference with someone… I think it comes with more experience in the field, being able to tell when it is a clear boundary line or when it is ok to indulge the person… you kind of learn the balance that everyone talks about, the dance between the therapist and client."

I found this comment from a participant to be so insightful. And I feel that it encapsulated much of how the participants experienced boundary difficulties and accepted their position as trainees in the process of growing and learning. This will be illustrated further in theme (5), learning from the experience.

P6 was the only participant who seemed to reflect on the client's understanding of boundaries and boundary difficulties, and explained that "they don't have the same understanding of boundaries as we do". P6 remembered a decision she made with a client and explained: "That was very difficult, I mean the decision was in a colloquial term 'a fail' and I was very conscious of it through-out the session, thinking 'oh my God'… that was an actual boundary." P6 explained that "as far as theory is important to build the base, it can't build all your professionalism, because experience and practical training have to come with it".

Participant seven (P7)

P7 shared several challenges, and she was very frank in her responses. She was open and used the interview to reflect on boundary difficulties and shared insightful comments. It felt like P7 had gained some insight from the opportunity to explore and reflect on her experience of boundary difficulties. This was my last interview, and was perhaps the most relaxed and also most probing interview. P7 seemed very aware of specific challenges she experienced, and tended to reflect on boundary difficulties more

broadly, across casework, where as other participants tended to stay with one example. P7 explained “there is definitely a little bit of panic I think when something doesn’t go right, and that trainee anxiety, it’s so intense…”. This is discussed further in theme (4e), feeling evoked, where participants describe wondering at times what to do. “Should I do this, should I not, am I doing it right, that kind of thing.” (boundary decisions). “Anxiety takes over quite a bit, some confusion, but a lot of anxiety around it.” “You have to be able to reflect on where your mistakes are, where the other person’s mistakes are and how to use them.” This will be discussed further under theme (5a), self-awareness and reflective practice. P7: “I think it’s something that should happen throughout your career and lifespan.” “The theoretical side is definitely important, but it often lacks the real feeling of what it is like when it is really happening, the actual involvement.” P7 described working with a supervisor/supervision as being very important in the process of understanding the boundary difficulties, and made reference to a Walt Disney character, who exclaimed: “Jiminy cricket, you know, the consciousness, outside the conscious, outside of you.” P7 explained this as having a neutral stance, that supervision could provide that. “I definitely think the point to emphasize is the difference between theory, and to understanding from sitting in a room, engaging with a boundary issue because they don’t fit into like these neat little categories.” This is discussed further in theme (5), learning from the experience. It was quite ironic that this was my last interview, and reflecting on the transcript and listening to audio recording again, I realised that in a way I was looking for these neat little categories in my attempt to make sense of the participants’ experiences of boundary difficulties. It made me conscious of approaching their experiences without looking for little categories.

P7 understood boundary difficulties as “little defining moments, where you learn about the boundary issue but that’s not where it ends, you learn about yourself too”. I found the participants to have such profound statements, and I wondered if they realised themselves how powerful their words were. I felt there was so much meaning in what they said, and I suspected it was not apparent to them. This will be discussed further in theme (5) Learning from the experience.

Reflections on analysing the transcripts

Analysing participants' transcripts made me aware of the potential to be drawn into a type of categorical thinking. This would entail looking for clarity as opposed to meaning, and looking for structure, rather than exploring experience. It offered some insight as to how I should approach the data. I found that I could be drawn into a black and white, rigid or structured way of organising or approaching the data, tempted to place heading, categories and the like. To try to make sense of the unknown, unclear, confusing experience. It made me aware of the need to step away from structure, headings and categories to make sense of the boundary difficulties. Reflecting upon this process was vital. It was also important to recognise how my theoretical interests could influence how I engaged with data, again, initially looking for the structure, model or framework to fit the experience into. For example, I often found myself tempted toward interpretations of an ethical nature due to my interest in ethics in psychotherapy.

Superordinate and subordinate themes

The themes below are a representation of the participants' experience of boundary difficulties. They serve as an organising framework of the analysis (Pietkiewicz & Smith, 2012; Waite et al., 2015, p. 1205).

Anonymised quotes are used to reflect participants' experiences to ensure transparency of data and confidentiality of the participants. Where possible, participants' words were used verbatim to label the themes.

Table.2 Superordinate and subordinate themes

Superordinate themes and subordinate themes
1. Boundaries are ‘the rules’ (1a) ‘anything ethical’ (broad and all-encompassing) (1b) an ‘unseen line’ and the ‘unwritten rules’ (grey) (1c) clear and distinct (black and white)
2. Boundaries function as ‘the scaffolding’ (2a) difficulties around time (i.e. keeping time) (2b) the space or environment (2c) self-disclosure (2d) maintaining professionalism (language, role and clothing)
3. Boundaries form ‘a security catching net’ (3a) a type of tool that regulated the therapeutic interaction (3b) a support within which the relationship can develop
4. Boundary decisions (4a) ‘wrapping up’ (4b) ‘who the therapist is as a person’ (4c) ‘human element in responding’ (4d) ‘working with children’ (4e) ‘feelings evoked’
5. Learning from the experience (5a) ‘self-awareness and reflective practice’ (5b) ‘supervision’

1. Boundaries are ‘the rules’

(1a) ‘anything ethical’ (broad and all-encompassing)

The first superordinate theme captures how participants make sense of boundaries in psychotherapy. Participants were asked if they could describe what they understood about boundaries. Participants seem to have understood boundaries to be related to any ethically appropriate interaction. In this way, they made sense of boundaries as being the ‘rules’ that govern the practice and nature of interaction in their therapeutic work.

Boundaries as the rules were understood as being contrasting, with some rules being clear and others not so clear. Participants understood boundaries through a very broad and unspecific description, as being 'anything ethical' (1a), referring to all ethically appropriate practice. In this way, participants identified boundaries in psychotherapy as all-encompassing, governing all therapeutic interaction in psychotherapy.

> P: "(sigh)…It's like anything ethical, like a line (pause) the unseen line that you can't pass professionally" (participant 2).

(1b) An 'unseen line' and the 'unwritten rules' (grey)

Participants explained that the rules are an 'unseen line' and that there are 'unwritten rules'. A participant proclaimed that "in psychology everything is grey" (participant 1) and that boundaries are "just this big umbrella of grey" (participant 4). Boundaries were made sense of as being unseen and unclear.

> P: "Oh my God! It is unwritten rules, like so many of them (pause), it's like you can't find them anywhere" (participant 1).

> P: "there are specific ones…but it is an unwritten rule, like the actual standard, so that you can understand this is what you don't do and this is what you do" (participant 4).

(1c) clear and distinct (black and white)

Boundaries as the rules were also contrastingly identified as being 'clear and distinct' (1c). For example, another participant explained that boundaries are the 'black and white' (participant 4) rules. Another participant explored the idea of an 'ethical boundary' (participant 6), a code or a line that serves as a limit of professional practice that cannot be crossed.

Participants understood boundaries on the one hand as being clear. These were the rules clearly outlined in documents, such as policies and procedures for professional conduct. On the other hand, they understood them to be unclear and experienced as elusive in nature, knowing about their existence but not being able to find them anywhere.

Boundaries ‘as the rules’ were experienced by participants as juxtaposing. This disparity is what lead participants to experience them and describe them as ultimately ‘difficult to know’ (participant 6).

> P: “Everybody says you can’t do certain things and you have to carry yourself a certain way and you just don’t know. Like, (sigh) it’s so difficult to know” (participant 1).

Participants made sense of boundaries as being the rules. They expressed that these rules, although some clear and others not, were ultimately difficult to know and be certain of. Participants seemed to attribute some ambiguity to boundaries, when initially making sense of ‘the rules’ in psychotherapy. Their use of metaphors, strong language, and sighs of frustration during the interview process gave the researcher an initial impression of embarking on a ‘mission impossible’. The disparity and understanding of ‘the rules’ as being inevitably difficult to know, informed the researcher’s understanding of what seemed to be a cautionary undertone in the participants’ narratives. This informed the researcher’s opinion that participants understood boundaries as ominous and to be approached with a foreboding sense of difficulty. Participants likened boundaries in psychotherapy to ‘muddy waters’ (participant 3) or a ‘slippery slope’ (participant 4) that needed to be circumnavigated and managed.

2. Boundaries function as ‘the scaffolding’

The second superordinate theme captures the elements that make up the framework within which the therapeutic interaction takes place. Participants understood their boundary difficulties in relation to aspects of the therapeutic frame. They made sense of boundaries as forming a type of scaffolding structure. The scaffolding served as a guide within which decisions were made, it helped to facilitate and maintain ethically appropriate interaction. (Aravind et al., 2012; Gutheil & Simon, 2002; Milton, 1993; Mc Williams, 2004; & Myers, 2000). Participants understood aspects of the therapeutic interaction such as keeping time, choosing the appropriate space or environment to work in, making decisions about how much to disclose about oneself as a therapist and understanding the therapist’s role, as components that make up what forms the

therapeutic frame and functions as a type of scaffolding, supporting and guiding the therapeutic interaction.

(2a) Difficulties around time (i.e. keeping time)

Participants identified boundary difficulties in relation to the therapeutic framework. They described aspects of therapeutic interaction such as 'difficulties around time' (2a), keeping time during sessions and difficulties managing appointment times.

> P: "Umm, so it's things like time, Umm, that's probably my biggest boundary issue" (participant 2).

> P: "[it] was hard… not being firm with the ending of a session, sticking to the time frame when he [the client] arrived half an hour late the one day, I had to just do a half an hour session" (participant 4).

> P: Time, you know, not allowing the client to be late every time… I had to be strict about the time… and that was very difficult… Umm, you know you don't have any other time except that time" (participant 3).

(2b) The space or environment

Participants made sense of their boundary difficulties, in relation to the therapeutic frame or "scaffolding" as also including aspects of negotiating fees, and decisions around 'the space or environment' (2b) or the room within which the therapeutic interaction took place.

> P: "It's things like money, physical space, self-disclosure, all of those things is boundaries" (participant 2).

> P: "a space, a consistent space, so they [the clients] know what's expected every single time" (participant 4).

> P: "I guess it's that space between you and your client. That you treat them like someone you empathetically care towards and are interested in working with

> and getting to understand. At the same time maintaining that space so that you are not becoming too meshed in the situation. Umm, that space to negotiate comfort and sort of also professionalism, so being close enough for them not to feel that I am not there but also enough space for both of us to feel comfortable" (participant 5).

> P: "A physical boundary, that space to negotiate comfort and sort of also professionalism, so being close enough for them not to feel that I am not there but also enough space for both of us to feel comfortable" (participant 7).

(2c) Self-disclosure

Participants explored 'self-disclosure' (2c), such as making decisions about how much information to share about themselves. They considered how to respond when clients ask personal questions and what to do with information about themselves that is physically or visually apparent, such as their age, gender or being visibly pregnant. Participants discussed and explored these areas in relation to maintaining professionalism, managing the therapeutic interaction in a professional and ethically appropriate manner.

> P: "They ask, 'Are you married?'; 'do you have kids?' and you know, those are some of the boundaries we try not to cross, we reflect the question back to them. But if it's a child, it's quite difficult to do things like that" (participant 6).

> P: "I had a client who was a child… I was pregnant and his mom had abandoned him and so… he was curious to know if I am pregnant and at some point, I thought that disclosure will not be the right thing but... My point was that I had to disclose, I said 'yes, I am pregnant and how does that affect us?' and then he was like 'no, I was just asking'. But you know, I realised, if I said why you asking or hadn't answered the question, it would have changed the relationship, because I was clearly pregnant" (participant 4).

Participants seemed to be very aware of the inherent risk in self-disclosure, and at the same time were confused about how to maintain the boundary of being professional but

not inappropriately cutting off or not responding to a client in a human way, and risk damaging the therapeutic relationship or rapport. Self-disclosure is often one of the first boundaries to go and the therapeutic interaction can soon become an informal, friendly style of interacting that no longer has treatment goals associated with them (Aravind et al., 2012). In negotiating boundary-related difficulties, participants made a conscious effort in their decision-making process to avoid boundary transgressions. They were conscious of keeping their client's best interest in mind.

(2d) Maintaining professionalism (language, role and clothing)

The research participants explored boundary difficulties around 'maintaining professionalism' (2d) and the therapeutic relationship. For example, their use of language, in terms of how they would talk to a client, and how it differentiated from talking to a friend and understood this as part of outlining and maintaining their professional relationship.

> P: "Once you have those boundaries it's much easier to work with them … you know boundaries in terms of how we relate to each other, how we talk to each other. I'm not the friend… so in terms of that… for me it's just the language and the role, that's identified early" (participant 6).

Participants seemed aware of the role of the therapeutic framework, in that it allows for the relationship to be therapeutic. Participants seemed to take these decisions seriously and were mindful of how even the way they spoke could impact the relationship or be considered a transgression. Participants discussed maintaining the therapeutic relationship and professionalism within the therapeutic interaction as a professional role and responsibility. For example, keeping clear the distinction between a therapeutic relationship and other relationships and establishing and maintaining the purpose and goals of the therapeutic interaction.

> P: "I guess the sort of things like your relationship with a client, keeping it as a therapeutic relationship" (participant 3).

> P: "Knowing what your place should be, for this person in their life… your role… as a therapist, not as a career or a lifetime attachment figure. So, it helps

> to, appease your anxiety in a way, because you know I'm just following the boundaries and sticking to what my role is. And defines it clearly, Yeah, like how to be, like what and how to react in situations" (participant 4).

> P: "when you make it clear that I'm your therapist and certain things can't happen and certain things will affect this relationship and this is how this relationship functions. Yes, it is a relationship but totally different to the other relationships you desire. If the therapy continued I would feel like, I would have crossed a line. Instead of being a helper… and there for you, I would have been like, now I'm friends" (participant 1).

Participants spoke about difficulties such as staying within their role and scope of practice, and maintaining that, within the therapeutic relationship there are limits to one's role.

> P: "With another case I struggled a little bit, in terms of not wanting to go over and beyond what was necessary or what was expected of me" (participant 7).

> P: "So struggling to maintain that this is what I can do, … going and sorting out the school for the client that's not my scope of practice" (participant 5).

> P: "you got to eventually learn, I think in time you learn to say no. Just I can't do that, out of necessity more than, out of protectiveness. Saying 'I'm sorry I've taken on all that I can do' " (participant 2).

The therapist's role in the therapeutic relationship is to maintain professional responsibility, establish and maintain confidentiality, and offer a neutral stance and have respect for a patient or client's autonomy (Myers, 2000). With a keen awareness and focus on acting in the best interest of the client, participants seemed to revert to the ethical principles of beneficence, non-maleficence and autonomy (Allan, 2011). They seemed to hold strongly that their role was to always act in the best interest of the client or patient.

In the process of making sense of their boundary-related difficulties, participants also discussed the importance of dressing appropriately as part of maintaining the professional boundary. They explored difficulties around the decisions of appropriate clothing for the type of therapeutic approach or clothing specific to the client, such as when working with children, and making conscious decisions to wear clothing or dressing appropriately to effectively work with children.

> P: "Working with the children and doing play therapy… That is very much physical and hands on… so that the level of professionalism takes on a different sort of dimension… [O]f course you have to dress appropriately" (participant 5).

3. Boundaries form 'a security catching net'

The third superordinate theme captures how participants made sense of boundaries, integrating their function and form in psychotherapy. They described boundaries as being a form of professional protection, "a security catching net" (participant 2) for therapeutic work. They understood them as a framework within which the therapeutic interaction took place.

> P: "boundaries create some sort of framework where you can operate" (participant 2).

> P: "It gives it structure, I think. It can be used as a tool, as a therapy tool" (participant 7).

It was clear from participants' accounts that boundaries were universally understood as being a protective measure. This is despite the disparity in knowing what they are, as highlighted by the first superordinate theme. In describing their experience, participants identified boundaries as being a protective measure in therapeutic work. They understood boundaries as acting as a safety net and as having provided a safe space within which to work. Participants felt they protected both themselves (therapist) and their clients from harm.

> P: “So it’s more a form of psychological and physical protection for both therapist and the client. That’s always the way I kind of understood it” (participant 3).

> P: “It is things like, it’s creating a secure environment and that kind of thing, setting boundaries to protect yourself as well as your clients” (participant 5).

> P: “Boundaries are more of a protective factor to me, so something to just keep the client in a safe place as well as yourself as a therapist. So, that no one can turn around and say that you have done something to them, should something happen” (participant 6).

(3a) A type of tool that regulated the therapeutic interaction

Participants made sense of the ‘security catching net’ in a very matter of fact way, lending to a sense of certainty and security in the function of boundaries as a metaphorical net. Participants seemed to have made sense of the ‘security catching net’ as ‘a type of tool that regulated the therapeutic interaction’ (3a). Participants portrayed a sense that they can be relied upon, and they offer something to fall back on when faced with a boundary difficulty. Participants attributed a very specific and significant role for boundaries in psychotherapy, for example providing a wide reaching and encompassing canopy for therapeutic work, that offers a type of clarity and certainty in situations where it may not be easy to know what to do.

(3b) A support within which the relationship can develop

Participants’ accounts revealed an awareness of this as ‘a support within which the relationship can develop’ (3b). In this way, despite the difficulties of managing boundaries, participants felt they had something to guide them through ‘the muddy waters’ (participant 3) and knowing that there was this ‘security net’ (participant 2) seemed to offer them a sense of confidence to engage in therapeutic interactions and navigate and negotiate the boundary difficulties.

> P: “I think that they definitely create a little bit of a structure for us. It’s not always easy to know what to do especially if your clients come late every

> week… So, by knowing this is not ok, you have to set that boundary… to like say no, actually sorry you have arrived half an hour late, and we have an hour session" (participant 3).

Participants made sense of boundaries as serving a significant role in the therapeutic interaction, safe guarding the process, the therapist and the client.

4. Boundary decisions

The participants spoke about the process of making boundary related decisions, and how they need to be negotiated.

> P: "I think you need to negotiate them. I think you need to experience them. You need to apply them because you grow when you do it…It's easier not to put boundaries in place, but when you do its therapeutic" (participant 2)

The participants explored the notion of negotiating the boundary difficulty and how their decisions impact on the therapeutic relationship. Participants clearly understood it as their role as the therapist to maintain the professional working relationship and to navigate and negotiate moments of boundary difficulty.

(4a) 'wrapping up'

Participants identified the decision-making process itself, as being difficult. They explored moments such as when faced with decisions around 'wrapping up' (4a) such as how and when to wrap-up a therapy session. For example, when at the end of session, they were unsure or uncomfortable to ask a client to leave, if the client lingered over time. The experience of needing to keep to the time-limit of the session, was a difficulty that participants felt led to an awkward moment, where a boundary decision needed to be made, such as whether or not to allow the client to dawdle or how to say that the session has concluded and politely usher them out.

> P: "Often you will try, I will be wrapping up the session and then he will start a new, bring up something new, completely new that hasn't been discussed in the session. And then you are stuck wondering, okay well there's literally two and

> a half minutes left. And he has given me this dilemma that he is going through now at the end" (participant 3).

> P: "There were quite a few times where the session had ended, and I will be packing up and he [the client] is still in the room [not leaving]. And I, not knowing how to tell him to go, without saying 'get out now'. [He] want[ed] to start small talk, like 'when are you going to have children?', 'when are you going to get married?' and all these things" (participant 6).

Participants seemed to be mostly frustrated by this boundary difficulty, rather than deeply concerned with it. It appears there was also an expectation on the client or patient to also respect and participate in maintaining that boundary, an expectation that they should know not to ask personal questions.

The literature on boundary difficulties discusses the experience of difficult moments in the therapeutic interaction, such as ending a session. Ending sessions are known for creating specific vulnerable moments, where the therapists' professional guard is often let down (Allan, 2011). Allan (2011) explains that each of these moments pose unique opportunity for experiences with boundary related difficulty. Focusing on a moment in the therapeutic session, Allan (2011) explains that the end of a session is a moment of vulnerability, amongst other things, "a time when some clients may try to extend the time boundary" (p. 175). Like Allan (2011), the participants also recognised that the client at this point, was the likely wrongdoer. Participants identified moments of these experiences, and recognised that each posed a boundary difficulty that required circumnavigation.

These boundary difficulties for participants appear to be related to the boundary difficulties of time, but are perhaps not as clearly identifiable in most settings or scenarios. These are not always the most obvious or clear-cut situations that a therapist or trainee would experience as a difficulty.

> P: [A situation with a particular client] "made me aware of how easily boundary issues can happen. So, with him there were clearly a lot, staying after the session

> had ended, asking questions and bringing his child with him. So, all of that [was] very unique, especially to experience as a therapist in training when you have so much anxiety as it is. So, it made me realize more, that boundaries can be violated and crossed very quickly even unintentionally, without even knowing that it is happening" (participant 6).

The participants experienced moments waiting for clients who are running late, and making decisions whether to still see them or not, answering calls from clients, and deciding when or how many calls were appropriate or when does it become inappropriate. Running over time during a session was experienced as a boundary difficulty and one that needs to be carefully negotiated taking into consideration the participant's personal and professional boundaries.

> P: "My client did things like come twenty minutes early and then just sitting and waiting expecting to be seen. Or phone multiple times, before a session, expecting to get a hold of me every time, to either confirm the session or expect me to walk up to the top parking and guide them into the clinic" (participant 7).

> P: "It was difficult to draw that boundary, it was difficult to kind of be effective, to be caring and not rejecting. Particularly if she started discussing something quite personal or a personal fear, to try and stop it and say, 'We can't start that now, it's too late', and then I realised that I needed to be conscious of time, specifically, with this client" (participant 2).

Making decisions was experienced by participants as a difficult process replete with confusion and feelings of being overwhelmed.

> P: "it is a very blurred, difficult process" (participant 6).

> P: "you sit there and you start thinking about a hundred million things" (participant 1).

(4b) 'Who the therapist is as a person'

Participants attributed several factors such as ‘who the therapist is as a person’ (4b) and who the client was, as impacting or determining how the boundary difficulty was experienced and managed.

> P: “I had a client much older, it was quite an interesting boundary challenge in a sense because of who I am as a person naturally and who she was and how she was expressing where she was and what she felt. After our first session, [I experienced a] very warm and very maternal type of vibe from her. As she stood up, she kind of grabbed me and hugged me. And obviously, I am a small person, so there wasn’t, umm, my instinct was not to resist, because to me that would have been damaging to the therapy and to the relationship and this was a woman who spoke about the fact that she had been alone and she needed it. And so, for me that was an interesting experience because it wasn’t that I had crossed the boundary, but then how do you react?. Do you say, ‘please don’t do that again’ or when someone is opening up to you and engaging especially if she hasn’t, you know… That was quite an interesting experience for me especially as well because my personality is very affectionate. I come from an affectionate family so it wasn’t un-natural for me to do that but I would never have engaged in it or I would never have initiated it. And it would have been very different if it were an older man, or a younger man. And context influences everything really” (participant 7).

> P: “Because of the type of person I am, I don’t believe in rigid boundaries. I am not a ‘black and white’ type person. There’s flexibility, there’s negotiation, and it’s to know where that boundary lies. And I suppose that’s what I battle with and where to draw the boundaries, where to draw that line… you don’t want to overstep boundaries because they are necessary for it to be therapy” (participant 2).

> P: “children like to come and get a hug. So, that was always a difficult issue, where I knew professionally that wasn’t appropriate. But on a personal level to me it’s how I connect with the children and how I help them to feel loved and welcome” (participant 3).

(4c) ‘Human element in responding’

Participants expressed a need to respond and empathise with their clients, in a way that felt real, not cold or rigid. Participants had a keen awareness and concern for maintaining their authenticity when responding to clients, conscious of not losing the human element, and working toward finding the balance between being a person and a professional. In a way that was guided by ethics and rules, to be conscious of, but to not hide behind these and lose the emotional, ‘human element in responding’ (4c) to clients.

(4d) ‘Working with children’

Particularly when ‘working with children’ (4d), participants also discussed the importance and value of sometimes allowing the process to unfold organically and not being too rigid in following boundaries that could be crossed without doing harm.

> P: “So definitely trying to be like (pause) okay, matter of fact about it, and really trying to get as much information and probing for more and give her the space of just being able to tell the story without someone showing that I actually just wanted to leave because it was so hectic” (participant 7).

> P: “I kept quite a professional boundary, and then as the relationship developed, things became warmer. It was easier to be more empathetic and genuine at that point rather than just sort of understanding (nodding head gesture) and taking notes” (participant 4).

> P: "Having a child [the client] upset and crying, you become more of a mother figure or someone to like care for them… For me it would be quite comfortable and I wouldn’t have a problem with it. I would encourage the child to come to me for comfort. I think, having to say no and to stop the child would be a form of rejection and could compound the trauma… to meet an immediate need, or short term need, I wouldn’t feel uncomfortable” (participant 5).

Participants described having difficulty with making decisions around the space in which the therapeutic interaction takes place. That is, the physical space in terms of distance between themselves and the client, and positioning of seating in the room. A participant discussed a therapy session working with a child, and how the consideration of space in terms of seating arrangement was considered as a way of establishing and maintaining rapport. A conscious decision had to be made to improve or benefit the process.

> P: "I thought it would be okay in my professional engagement to try and be with the child in a way that wasn't like when anyone else was with him" (participant 6).

> P: "I was always right next to him, even during his assessments I didn't sit opposite him on the assessment tables like you should. I sat next to him making sure, obviously, that all the material was out the way but making sure that he didn't feel like it was he and I, separate. Like it has been at school. Because he kept being isolated by the teacher and I didn't want to play that out, so in terms of boundaries there I didn't physically maintain the recommended distance between the child and myself, and if he wanted to play I played" (participant 1).

Participants described being aware of their experience and consciously made decisions while keeping their clients' best interests in mind, with an aim to do no harm, even if it meant going against the norm or being slightly uncomfortable themselves. It was a process of negotiating and making boundary related decisions.

Similar to the decision around physical space and distance between the trainee [therapist] and client, was the experience of the difficult decision about physical contact. The participants expressed difficulty with the decisions around physical contact, such as a hug, particularly when working with children. Deciding on whether it was right, wrong, useful or detrimental was a particularly challenging experience for the participants. Coupled with trying to make sense of their own decisions, participants found themselves trying to make sense of others' decisions too. They expressed the challenge of witnessing colleagues engage in physical contact such as hug, in situations

they themselves would have not deemed it appropriate. Participants explored and unpacked their experiences, they initially identified and understood the boundary as one that was quite simple and clear-cut, "touching is a no", with professional ethics, policies and guidelines supporting this approach. The difficulty they experienced came with the experience itself, and was very much context specific, being faced with a decision to make in a moment, and knowing that the decision will affect the therapeutic alliance and process of therapy moving forward. Examples that participants gave were scenarios such as when a child runs up to you for a hug you before a session, or when a client, after an emotional outburst in a session, leans forward and hugs you.

Participants expressed anxiety around making decisions about receiving gifts from clients or leaving clients with parting gifts or symbols of the therapeutic process. The participants discussed the act of giving a client something, and how that action can change the relationship from one that was previously professional to one more friendly in nature. Be it a gift, or a token of remembrance of the therapeutic process, the participants discussed it as their responsibility to remain aware of these decisions and be clear about what the professional limitations are.

> P: "Leading to the session, I knew this child had abandonment issues and attachment issues. Leading up to the end of the session, the child asked if they could have the pack of cards we played with. And I said 'I can't give you those cards because the pack of cards belongs to the clinic' and I tried to explain this" (participant 4).

> P: "I was wearing bangles on my hand and the child says to me, 'can I please have one of your bangles?' I looked at him and like, you know (Sighs)… 'This seems very important to you to have something'… and he was like 'no, I just like them and I just would like to have one' and I'm like, 'well I'm sorry but I can't give you one. But you do walk away with everything that we shared in here together and' (because he had done a body mapping), 'you get that and we will always have that…You will always know that if you need help there are people out there to help.' Yeah, but I felt so bad afterwards (sighs) I was like; I should have just given him the bangle" (participant 1).

Generally, both receiving or giving gifts in the therapeutic interaction is deemed inappropriate in most codes of practice. However, context and case specific settings may arise, where these decisions are placed under consideration and can be deemed as helpful to the therapeutic process and thus appropriate (Allan, 2011). Participants made this decision only after consultation.

Working with children posed unique and specific boundary difficulties for participants.

> P: "In the therapy you want to form that alliance. But you still want to be able to set a boundary if the child starts throwing toys or something… there are times when you're going to have to say… 'It's not you it's your behaviour', 'It's not you personally, but in this room, we don't throw the toys'" (participant 2).

> P: "Like I play cards in our sessions with him, like the whole sessions… and someone else may look at that and be like… 'How is that helpful?' 'Like what did that do?' And 'maybe you shouldn't have done that'…that distracts the whole situation, you meant to have one on one therapy and these things (Laughs)" (participant 1).

(4e) 'Feelings evoked'

When discussing boundary difficulties overall, participants expressed feelings of guilt, responsibility and regret when making these boundary decisions. Participants explored the different 'feelings evoked' (4e) when making boundary related decisions or when faced with boundary difficulties. They expressed feelings of regret, anxiety, guilt and incompetence relating to their boundary related decisions and difficulties. These feelings are the therapists' own training related anxieties specific to their training year. Participants described their experience of boundaries and boundary difficulties as encompassed by feelings of uncertainty, doubt, fear, and worry. Trainee therapists are mostly aware of their feelings of anxiety and they often reflect on them in terms of it being a part of the process of learning, their growth and development as psychotherapists. They are identified through reflective processes and accepted as necessary for, and lead to their development.

> P: “I feel like I handled, I don’t know if I handled. I don’t know if I did well (nervous laugh). Like you feel like in the moment in time, you moved the situation to a point where you felt or you feel that it is working for the person… you don’t feel relieved. You don’t think you did well, you feel, you feel, you still feel on edge. Did I say it properly, did I say the right thing, in the right way, was it received in the way I wanted it to be received?” (participant 3).

> P: “In the beginning honestly it felt like he was spinning the room around me and kind of making me feel silly, it was difficult. I didn’t have confidence in the beginning” (participant 7).

> P: “I just remember feeling disappointed in myself for not being able to say, ‘your child is safe here. Just let her sit outside.’ So, I felt like I was letting myself down as professional, and letting him down as a therapist” (participant 6).

Participants were aware of the feelings evoked by difficult boundary experiences and reflected on them in terms of their influence on the therapy, as well as the development and growth the experience allowed for the therapist. Participants described their own feelings and experiences with their clients during the therapy process. They identified feelings of fear, frustration, anxiety, guilt, and responsibility around their experiences of boundary difficulty.

> P: “managing my feelings, I had to get used to kind of being uncertain about myself. And you know the whole sitting in the moment and that was my first big taste of what it really means to be like, I am not sure what to do here, what feels right, is the guideline and work through that” (participant 7).

> P: “I just felt really awkward, must have blushed a bit I guess” (participant 6).

5. Learning from the experience

Participants expressed the value of learning through the experience of having boundary difficulties and needing to work through the decision-making process. Participants

reflected on how the experience allowed for growth and provided insight into aspects of life they would have not considered, such as a child's experience or perspective.

(5a) 'Self-awareness and reflective practice'

Participants reflected on how the experience was also a valuable component of learning about themselves as therapists, through 'self-awareness and reflective practice' (5a). They highlighted the importance of knowing oneself and knowing what one's own boundaries and boundary difficulties are.

> P: "The boundary difficulty was also insightful. It made me think about how kids feel about a lot of things, in their life. There's no structure in their days and obviously, things for them are procedures that are chaotic. And suddenly they don't get the full amount of what they want, but the entire situation with their therapy and whatever it is. Which then again was very insightful, so all the boundary issues were for me very telling, it tells what is happening, the real-life context. So, I found, as frustrated as I felt at times, they were very revealing" (participant 3).

> P: "Knowing yourself actually and knowing that these are, umm, this is what I stand for and this is where I stand and maintaining, not so much maintaining but building you up, to being a certain type of therapist as well. I think it is so important and I think they, they act as little defining moments, and you learn about the boundary issue, but it's not where it ends, you learn about yourself, you learn about how you want to go forward etcetera and how you can apply it to further things" (participant 7).

> P: "there is so much growth in those panic moments and post panic and moving through a boundary issue, I think it is such a crucial area of growth. I think it's so important towards building yourself as a therapist, it's kind of adding to your repertoire of basic engagement with a client" (participant 7).

Participants highlighted reflective practice and self-awareness as ways of identifying and understanding their feelings. Participants viewed this as beneficial for the

therapeutic process and their development as therapists. Zeddies (1999) explains that "[m]any voices clamour for attention in a student therapist's head during a session, and in the developmental process from student to seasoned clinician, a therapist learns to become a better listener to both him/herself and to clients" (p. 234).

> P: "I think the biggest thing was self-awareness, understanding my own past and my own countertransference, to maintain that and be aware of that" (participant 2).

> P: "[It takes] a lot of self-reflection. I think that was key because otherwise I sat with all these emotions and all these feelings, not knowing what my actual feelings or thoughts were exactly, instead of being bombarded by a whole lot. What particularly helped, I think it is the self-reflection was the biggest thing and in terms of process. I think it forced me to be more involved" (participant 3).

The participants explained that theoretical knowledge was important, but just as important was learning through experience (Bhola et al., 2015; Urdang, 2010). Participants explain that learning from a book or lesson is different to learning from first-hand experience and that both are necessary for the development of a trainee psychologist. Some participants felt they were prepared for their experience of boundary related decisions from their theoretical knowledge and others felt they were not. All the participants reported having theoretical knowledge and exposure to boundaries and boundary difficulties, dating as far back as their first-year psychology lectures, and that even with all this behind them, it was only in the moment of experiencing the boundary difficulty where they could fully appreciate its complexity and understand its value in the therapeutic process. Theoretical knowledge prepares you, but you don't understand it until you experience it, the experience was where you really learned from.

> P: "I think there is like an awareness that there are going to be these issues but until you see them, you're not prepared for them. Cause you think, but you can't really fathom, the way certain people are going to interact with you and push

> your boundaries. It's almost like this theoretical faraway construct, umm so now I didn't feel prepared in that sense. I think that we were prepared theoretically. But not to actively engage and direct and move through the process itself and how to interact in that moment, if it's one you need to address straight away, responding to someone and being assertive enough to control the boundary is quite an intimidating experience and something I don't think anyone's prepared for" (participant 7).

Although participants seemed to be stilted in their approach at times, they also seemed to recognise that they must allow situations to unfold, and through reflection or in hindsight, expressed having learnt something when they allowed the process to unfold organically. Through their reflections, it was clear that participants allowed themselves to make mistakes and learn from their experience.

> P: "I realised that I needed to be conscious of time, specifically with this client. I mean it was kind of when you realise when you run ten minutes over and you think well that's not great" (participant 2).

> P: "I suppose it is just experience. Living in regret. So, you learn things, but until you experience them you don't realise the relevance. The experience brings it home, it makes it real. Boundaries are important to me (Laughs)… I have experience with boundaries" (participant 5).

> P: "I definitely think the entire view of a boundary issue, is completely different when you get here and again by the end of the year… you sit in the room with the client and go ok, so this is what it is" (participant 7).

The participants made sense of their boundary difficulties as having offered insight into their clients and the presenting problem with which they were working. Participants recognised that how they experienced and understood boundaries and the difficulties they faced, also determined the therapeutic relationship and how they negotiated the difficulty.

> P: "It allowed me to understand the client better as well, as you know reflection of what is happening outside in other interpersonal interactions. So, it guided me a lot… [about] areas that I need to be warier of, stricter on. It builds up an understanding of what he [the client] might be doing to others or how he might be making others feel" (participant 7).

> P: "I think that you need to internalise the boundaries, it's like, this is what's right and then the more experience you have, the more you act on it. And then this will be okay in one situation and then in another situation it will be like the worst thing to do. So, you should be flexible in a way. I think that only comes with experience" (participant 3).

(5b) 'Supervision'

Participants, in reflecting on their experience, highlighted the role that supervision (5b) played in facilitating the process of learning and making sense of boundary difficulties. The role of supervision was expressed in relation to the support trainees felt it offered. Participants felt that supervision fostered reflective practice, encouraged self-awareness and provided a sense of confidence that allowed the participants to learn from their experiences.

> P: "I think you kind of go through it blindly, and then ask your supervisor for assistance. If you have done something incorrectly you trust them to tell you in a gentle way, how to approach it better. Which a lot of the time it was like that, I would just read too much into something my supervisor would just say, 'it could mean that but it could also mean this and this and this and this, don't destroy your mental processes over thinking about what everything means, if the person stays two minutes after time or asks you a personal question or just very gently stay in one space where you don't over read everything. Especially as you are learning to find your professional feet'" (participant 6).

> P: "Working through supervision is so important, because it is almost like umm, supervision was so important to kind of put it into place and know that you or remind you that you are still doing a job, without breaking those boundaries.

> That you don't have an obligation to go further but an obligation to do what is expected of you and stop there" (participant 7).

Participants expressed a mild sense of frustration and confusion at times because of supervision. This related to changing supervisors and how this created confusion around how to manage boundary difficulties.

> P: "all of our different supervisors, suggested different things. But we generally, stuck to whom we were working with at the time" (participant 5).

Overall, participants expressed appreciation for the supportive and guiding role that supervisors and supervision offered especially when making decisions around boundary difficulties. They identified supervision as a specific component of their training year as having offered an opportunity for participants to make sense of their boundary difficulties.

> P: "I think if you didn't encounter them now then you don't get a chance to go back to a lecturer, to go back to a supervisor, and to work through it" (participant 7).

Summary

The above sections discussed participants' experiences of boundary difficulties in psychotherapy. The superordinate themes were informed and derived from the emergent transcript themes. Each subordinate theme highlighted the essence of the participants' experience. The superordinate themes highlighted how participants understood boundaries in psychotherapy. They also clarified how they identified their function, in relation to the therapeutic frame and their form in relation to protecting the therapeutic interaction. The superordinate themes reflected participants' accounts of moments in the therapeutic process they felt were difficult to manage, as well as reflecting accounts of making boundary related decisions and learning from the experience.

CHAPTER FIVE

DISCUSSION

This chapter discusses the study's findings in relation to wider literature.

Areas of boundary difficulty were derived from the researcher's exploratory notes and observations of the data, including descriptive, linguistic and conceptual aspects. Exploring the participants' narratives of boundary difficulties, the areas of difficulty reflect participants' commentaries and the researcher's interpretation of what was felt to have had both overt and implicit meaning and relevance to the participants' experience.

The data analysis informed the identification of thirteen areas related to boundary difficulties. These informed the emergence of five superordinate themes, each with subordinate themes that represent the essence of the participants' experience of boundary difficulties. The researcher undertook a process of identifying and labelling areas of difficulty. This process was informed by an idiographic approach, and involved exploring each participant's transcript individually, before making general comments or observations (Pietkiewicz & Smith, 2012). By way of organising the areas of difficulty, they were clustered per the number of participants having mentioned them. The table clusters were as follows; all, most, some and a few participants. The table displays a group overview of the types of boundary difficulty experienced by each participant. All areas represented in the table are relevant areas related to a boundary difficulty. Although all areas of prominence for the study, the aim of the table is to highlight some common and infrequent features of boundary difficulty between participants.

The most prominent difficulties identified were as follows; all participants mentioned a difficulty relating to (1) the professional [therapist's] role, (2) the space or environment therapeutic interactions take place in, (3) physical contact with a client such as a hug, (4) working with children. All participants mentioned (5) finding supervision helpful when faced with a difficulty, discussing the valued role it played in helping them make sense of their experiences.

When discussing their experiences of difficulties, most participants mentioned difficulty around (6) managing time, both during sessions and managing appointment times, difficulty with (7) decisions around gifts, giving and accepting in the therapeutic interaction and difficulty with decisions around (8) self-disclosure. Other areas of difficulty identified by some participants were around (9) the use of language in the therapeutic interaction, (10) dealing with one's own [trainee] anxiety and (11) working with the feelings evoked, such as panic, dread and feeling overwhelmed. Participants identified (12) reflective practice as being helpful in the process of making sense of their experience of boundary difficulties. A few participants discussed experiences of boundary difficulties relating to a participant's [therapist's] choice of (13) clothing.

The above identified areas related to boundary difficulties informed the key findings that follow.

Key finding 1. Boundaries understood as 'the rules'

Participants understood boundaries as being the rules that govern and regulate all therapeutic interaction. A broad and encompassing umbrella term referring to 'anything ethical'. Their understanding was closely aligned to the definitions of boundaries in the wider literature. For example, Allan (2011) notes that the norms of law, positive morality and professional ethics primarily define boundaries. Participants' understanding of boundaries highlighted their awareness of the disparate nature of boundaries in psychotherapy that are relative to their context. Although participants used different descriptive words, the implicit meaning did not differ. In line with the literature, a unanimous understanding was that boundaries delineate ethically appropriate practice (Audet, 2011; Allan, 2011; Gutheil & Gabbard, 1998; Robert Simon, 2011). I had anticipated that participants' accounts would reflect this theoretically-based understanding of what boundaries are in psychotherapy. However, what emerged unexpectedly from the findings was an honest sense of apprehension, on the cusp of an absolute dread. Participants' accounts presented a sense of foreboding around boundary related decisions. I made sense of the participants' apprehension in the light of what Glass (2003) explains as the 'grey area', a spectrum of boundary

related decisions that leads to a conceptual ambiguity because of the relativity of the boundary to its context.

Key finding 2. Boundaries understood as 'the scaffolding'

Participant accounts of boundaries in psychotherapy demonstrate an understanding of the role of boundaries in psychotherapy. Boundaries play an important role in forming and creating a structure that facilitates the therapeutic interaction. Areas such as time related decisions, the environment or space of the therapeutic interaction, each play a role in building on and maintaining 'the scaffolding' that supports and facilitates the therapeutic process. Participants' accounts of their difficulties around managing their time, keeping time in a session as well as setting appointment times, their understanding of therapeutic space and decisions around self-disclosure, gifts and hugging, each highlight their awareness of central elements of therapeutic interaction that constitute the therapeutic framework (Gutheil & Gabbard, 1998). Although participants identified different areas as being difficult to manage or make decisions about, there was a shared understanding that boundaries overall, offer a type of structure or platform from which to work that facilitate the therapeutic interaction.

What emerged from the findings was that trainees' experiences of boundary difficulties related to all aspects of the therapeutic frame. This included difficulties around setting up the frame: such as knowing one's role, establishing appropriate times and setting appointments. It also included difficulties within the therapeutic interaction, such as maintaining rapport, decisions around self-disclosure, gifts and how to maintain professionalism, for example through the use of professional language. In line with (Aravind et al., 2012), who understand the frame as outlining 'the edge' (p.21) of appropriate interaction, trainees' experiences reflected a profound concern related to making ethical decisions.

Key finding 3. Boundaries understood as a 'security catching net'

In describing their experience, participants identified boundaries as being a protective measure in therapeutic work. They understood boundaries as acting as 'a safety net' and providing for a safe space within which to work, protecting both the participants

(therapist) and their clients from harm. Participants understood boundaries in psychotherapy as offering a sense of certainty. In this way, despite the perceived foreboding difficulty of managing boundaries in psychotherapy, participants felt they had something to guide them through 'the muddy waters', they knew that there was this 'security catching net'. This seemed to offer participants a sense of confidence to engage in therapeutic interactions. It was clear by participants' accounts, that boundaries despite the disparity, were universally understood by participants as having provided a security net.

Participants were trained primarily through a psychodynamic lens in their masters' year of study. The participants seemed to embrace this in the way they made sense of boundaries and their boundary difficulties. Psychodynamically, boundaries were understood as a useful tool. Participants' accounts reflected a psychodynamic view that boundaries were always understood, experienced and dealt with relative to their context. Participants had a keen awareness that boundaries needed to be held constant. Participants understood that a constant and secure environment was necessary to facilitate the client's needs (Bridges, 1999).

The idea of boundaries in psychotherapy as a 'security catching net' highlights that for trainees, in the process of the therapeutic interaction they experience feelings of anxiety and ambiguity. Theriault and Gazzola (2006) explain that "psychotherapy is often an ambiguous process" (p. 314). Williams, Hill, Judge and Hoffman (1997) explain that trainees often find themselves concerned with being able to manage the therapeutic interaction. The relevance for trainees, in their experience of learning how to become a psychotherapist is the need to learn is to manage their anxiety. Boundaries, the therapeutic frame, or structure offered by professional boundaries, allows and "helps trainees to manage their anxiety" (Williams, Hill, Judge & Hoffman, 1997, p. 390).

Pica (1998) explains that working as a psychotherapist requires a certain tolerance for ambiguity. He explains that while "the work can be exciting and challenging on the one hand it has the potential to create a tremendous amount of anxiety" (p. 360). He explains that for a trainee "the ambiguous nature is of an even greater magnitude" (p. 360), and

that trainees must learn to deal with not always knowing the answers to problems they may face.

For trainees, there is safety in structure that the metaphorical 'net' provides. It allows trainees to engage in the multifaceted role of a therapist, attending to their clients' needs, engaging in active listening, accurately empathising, and setting goals, etc. within the safety of the established boundaries and structure. The safety net helps the trainees "to grasp the essence of their task and feel more confident" in approaching their client (Williams, et al., 1997, p. 392).

Key findings 4. Boundary-related decisions were 'difficult'

Making decisions around boundaries in psychotherapy was experienced by participants as a difficult process replete with confusion and feelings of being overwhelmed. The participants explored the process of negotiating the boundary difficulty and how their decisions impacted on the therapeutic relationship. Participants clearly understood it was their role and responsibility as the therapist to maintain the professional working relationship, navigate and make decisions in the moments of a boundary difficulty. Participants' accounts highlighted an expectation of the client or patient to also need to respect and participate in maintaining that boundary, an expectation that reflected a sense that clients have a responsibility not to ask personal questions. Participants found it difficult to be clear about what the client's role and responsibility was in the therapeutic process and how to maintain it when a client transgressed, for example lingering after the session has ended.

Participants' accounts highlight that for them knowing what boundaries in psychotherapy are was not what was most difficult, making decisions around them was. This is in line with what Bridges (1999) explains, where she says that "clinicians are well informed about ethical conduct and yet remain confused about how to understand and construct therapeutically useful boundaries in psychotherapy" (p. 299). Making decisions about what works for both the therapist and the client was what participants found difficult. For participants, setting boundaries and sticking to them, deciding what was right and wrong was very much a part of the difficulty they encountered. Glass (2003) explains that boundary violations are synonymous with unethical practice and

this leads to the right and wrong, black or white view of boundaries in psychotherapy. Participants' accounts highlighted the decision-making process of what was ethically appropriate practice, what the negotiables were and what the non-negotiables of their therapeutic interaction were. Pope and Keith-Spiegel (2008) explain a similar process they call "making decisions, bypassing blunders and mending fences" (Pope & Keith-Spiegel, 2008, p.638). They explain that "sometimes the intense focus on boundaries, the historic controversies, and the uncertainty and anxieties that some boundary issues evoke can make it seem as if decisions about boundaries are a strange and forbidding aspect of [therapeutic] work" (Pope & Keith-Spiegel, 2008, p. 638).

Key finding 5. Boundary difficulties provided learning opportunities

Trainees identified having learnt from the process and experience of boundary difficulties. They described the experience as having provided an opportunity to learn about themselves as psychotherapists, and the value of reflective practice and supervision in fostering the learning. The trainees' understanding of the difficulties involved in the process of making decisions related to boundary difficulties, are discussed by Nerdrum and Ronnestad (2002) as an awareness of complexity that was necessary for all professional development.

The process of becoming a psychotherapist was known to be fraught with stress and apprehension, complex interactions and self-discovery (Skovholt & Ronnestad, 1992). Recognising the complexity and ambiguity associated to boundary difficulties in psychotherapy, trainees expressed the value of learning through their experience of having to face boundary difficulties and needing to work through the decision-making process.

Bhola et al. (2015) explain that "trainee therapists grapple with the complexities and challenges of shifting from the known role of the lay helper to the unknown role of the professional" (Bhola et al., 2015, p. 1). Participants expressed an understanding that the experience of boundary difficulties, allowed for growth and provided insight into their role as psychotherapists, into aspects of life they would not have otherwise considered, such as understanding a child's experience or perspective, and how the experience was also a valuable component of learning about one's self as a therapist. Hill et al. (2007)

explain that trainees' early training experiences are likely to provide the foundation for subsequent learning and it was thus of great importance to explore and understand the processes involved, such as their experiences of boundary difficulties, in the process of becoming a psychotherapist.

Summary

The key findings are a reflection of the trainees' psychodynamic orientation of training. The trainees constructed their therapeutic boundaries, understanding them as a 'frame'. They used them as a built in structure to contain and 'hold' the process, a form of security. Psychodynamically boundaries are inherently difficult to negotiate as the trainees were able to decide what is therapeutic, and thus faced many more choices. In this process, the trainees valued mutuality and a greater humanness in their relationships with their clients. At the end, they made meaning through learning from their experiences of boundary difficulties.

The key findings of the study reflect similarity to the wider literature. Trainees' understanding of boundaries in psychotherapy, as being the rules that outline and regulate therapeutic interaction, was in line with work such as (Allan, 2011). Trainees' understanding of boundaries as the scaffolding or frame, and their experience of areas relating to boundary difficulties, was in line with the literature, through work such as (Gutheil & Gabbard, 1998). Trainees' understanding of boundaries as the security net, offering a protective measure for trainees, links to the literature, with work such as (Bridges, 1999). Trainees' experience of difficult boundary decisions links to work by (Glass, 2003 & Pope & Spiegel, 2008). And, trainees' understanding of boundary difficulties as being a learning experience, links to the literature through work such as (Bhola et al., 2015; Hill et al., 2007 & Skovholt & Ronnestad, 1992).

CHAPTER SIX

CONCLUSION

This chapter concludes the thesis. It offers an overview of the process followed and the research questions. The findings are linked back to the research questions. The chapter outlines the implications of the study and discusses the limitations of the study. It also offers recommendations for the future.

Overview

The aim of the study was to explore trainee psychologists' experience of boundary difficulties in psychotherapy. A qualitative approach was used to understand how trainees make sense of their experience of boundary difficulties. Data was collected through semi-structured interviews and analysed using IPA to address the following research questions:

1. What boundary difficulties do trainees experience in psychotherapy?
2. How do trainees make sense of boundary difficulties in psychotherapy?

The key findings relate back to the research questions. The findings reflect the trainees' understanding of boundaries in psychotherapy as the rules that govern and regulate all therapeutic work, encouraging ethically appropriate interaction. Trainees understood boundaries to function as a type of scaffolding for therapeutic interaction, in that they became a form of security net that facilitated and supported the therapeutic relationship. Trainees identified areas of boundary difficulty pertaining to the therapeutic framework, such as maintaining professionalism, managing time, and making decisions around space, gifts, physical contact and self-disclosure. Trainees highlighted moments such as ending therapeutic sessions, working with children and managing their own beliefs and expectations as particularly difficult boundary related decisions. Trainees identified reflective practice, self-awareness and supervision as providing support and facilitating the process of making sense of boundary difficulties.

The boundary difficulties were learning experiences, “little defining moments, where you learn[ed] about the boundary issue but that’s not where it ends, you learn[ed] about yourself too” (Participant 6).

Implications

This study has offered an understanding of trainees’ boundary difficulties in psychotherapy. This allows for these difficulties to be addressed and can guide the development of trainees’ skills. Understanding therapeutic boundaries and learning how to manage boundary difficulties is a part of becoming a psychotherapist. Learning from experience, how and why to establish appropriate and effective boundaries are important skills for all psychotherapists. The findings of this study can be integrated into the training process and may be useful to prepare trainees for and normalise their anxiety around negotiating boundaries.

A significant element of trainees’ experiences of boundary difficulties in psychotherapy was the engagement itself with boundary related difficulties, or boundary related decisions. Supervision helped trainees to make sense of their experience of boundary difficulties. Learning from the experience of boundary difficulties is an ongoing process for trainees. The findings of this study can be used to highlight to trainees that the skill of negotiating boundaries is one that is learnt through a developmental process and that it takes time and practice. Importantly it can also highlight to trainees that simply knowing the rules is not sufficient.

Boundary difficulties and boundary related decisions are an intuitive cognitive process that deepen a trainees’ understanding (Audet, 2011). A conversation about boundary difficulties is necessary for development and training (Audet, 2011). It is through facilitated discussion and experience that learning is taken to another level. Norcross & Goldfried (2005) explain that “every therapist who becomes an effective professional has to learn how to reflect [on their experiences] … we reflect on what we did or did not do and what we might do in the next session”. (p. 585)

The findings of this study highlight that boundaries need to be flexible in the process of negotiating. This may offer trainees a shift from understanding boundaries as fixed and constraining rules, towards boundaries rather being seen as guidelines to assist in making complex boundary related decisions. Boundaries need to be understood, respected and reflected upon. Boundaries are a topic to discuss and explore in all their complexity, across the continuum of development.

Limitations

Limitation of this study were the context specific limit to confidentiality and the use of only semi-structured interviews for data collection. As part of the study's research design, the study recognised the limit to confidentiality and measures for anonymity were taken seriously. To protect participants from being identified, demographic information was kept to a minimum and participants were assigned a number for reference. In writing up the study's findings care was necessary to randomise and anonymise the participant quotes, to prevent the chance of profiling of narratives, and participants being identified through their use of language or character specific responses. This led to study being unable to achieve as much credibility as it could have, if it could attribute specific participant quotes. In the study's data collection process, although the study used semi-structured interviews, which allowed for flexible and open-ended interviewing, the data could have been further enriched by the inclusion of a focus study. A focus group can in the future, can improve the studies dependability and credibility by providing different sources of data. In the study's data analysis process, an IPA approach was appropriate for exploring and understanding human experiences because of its ability to help the researcher to stay close to the data. However, although appropriate, this method has limitations including its reliance on people being able to adequately verbalise their experiences, and its emphasis on perceptions of phenomena without asking why questions (Willig, 2008).

Recommendations

- Further research on the experiences of boundary difficulties in psychotherapy for both seasoned psychologists as well trainees, which will allow for an understanding across the development span.
- Provide opportunities for trainees to participate in facilitated and supported discussions around boundaries in psychotherapy and boundary related difficulties. This will allow the understanding of boundaries to be taken further than a conceptual understanding for trainees, while demystifying and reducing apprehension around boundaries in psychotherapy.

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Appendices

Appendix A

Informed consent form

A Qualitative Study of Trainee Boundary Difficulties in Psychotherapy

This is an exploratory study of trainee psychologists' experience of boundary in therapeutic work. Like all therapists, trainee psychologists are faced with boundary related difficulties daily. The study seeks to understand what boundary difficulties trainees experience in their therapy sessions with clients. It will look at how trainee psychologists understand and negotiate boundaries in their therapeutic work and it will explore primarily what boundary difficulties they experience. The study will explore these boundary difficulties qualitatively, using semi-structured interviews and interpretative phenomenological analysis.

This research project is about the process of becoming a psychotherapist. The study is interested in the experiences of trainee psychologists during their training. The Study will explore boundaries and what boundary difficulties trainees experience in psychotherapy.

Research participants are students registered for the Psychology Masters, Clinical or Counselling programme. The participants' age, race or gender as well as the type of case, therapy or assessment used, are not areas of concern or focus for the study. Participants will be asked to participate in a semi-structured interview reflecting on their experiences of boundary difficulties in therapy. The interview will take approximately fifty minutes.

Research participants will be asked to give their contact number and email address for a follow up conversation during the research studies' data analysis phase.

Participation in this study is voluntary. Participants are free to withdraw at any time and their decision to participate, will in no way affect their course work or evaluation as M1 students.

To ensure confidentiality and anonymity, both within the department and out, only the researcher will have access to participants' personal details. Participants will then be assigned a number which will be used as a reference by only the researcher and research supervisor. The interview data will only be read by the researcher and the research supervisor.

As part of the ethical considerations for the research study and the ethical responsibility to research participant's clients, by consenting to participate in this research, participants confirm that they have and shall continue to abide by all rules and regulations contained within the Centre for Applied Psychology Clinic.

If there are any areas of concern or questions regarding the studies aim, purpose or role as a participant, the researcher will provide this information. A copy of the final report will be made available to all participants on request.

The research project is supervised by Professor Duncan James Cartwright and will be carried out by Mrs. Lamese Bryczkowski. For queries about this study please contact either Mrs Lamese Bryczkowski on mkdlam001@gmail.com or Professor Duncan James Cartwright on Cartwrightd@ukzn.ac.za.

By signing this consent form, you agree to participate in the research study explained and indicate that you fully understand the study, its aims and purpose as well as your role as a participant.

I _____am participating freely and understand that I can withdraw at any point should I choose to no longer continue and that this decision will not affect me negatively. I understand that this research project will not benefit or harm me personally, and I understand that my participation will remain private and confidential.

Contact Number _____
Email Address _____
Signature _____

Appendix B

Semi structured interview schedule

A Qualitative Study of Trainee Boundary Difficulties in Psychotherapy

Participant Number:
_____
Email & Contact Number:
_____

Theme 1: Boundaries in Psychotherapy

What do you understand about boundaries in psychotherapy? Can you give examples?
_____
What do these mean for you as a therapist?
_____
What influence or impact do they have on your therapy sessions?
_____

Theme 2: Boundary Difficulties

Reflecting on your cases thus far, what boundary difficulties have you experienced in your therapeutic work?
Do you experience these difficulties in a specific context or time?

Theme 3: Trainees Experiences

How would you describe your experience of boundary difficulties in therapy? (Focus on each one mentioned in Theme 2). (Probe feelings and thoughts at beginning, middle and end of boundary difficulty)
_____

What do you think made your experience this way? (Probe thoughts)
_____

Do you feel your experience could have been different in any way? (Probe actions)
_____

Theme 4: Counselling Skills

How do you usually manage these boundary difficulties?
_____

How do you think these boundary difficulties influenced or affected the therapy process?

_____

What strategies or skills do you feel helped you manage/negotiate these difficult moments?

_____

What do you think prepared you for the task of managing boundary difficulties in therapy?

_____

Theme 5: Becoming a psychotherapist

What does the experience of boundary difficulties in therapy mean for you in the light of becoming a psychotherapist? (Probe Self-Efficacy)

_____

Is there anything about your experience of boundary difficulties in therapy we have not covered, that you feel is important to share?

_____

(Approx. 50 minutes per interview)

Appendix C

Permission to conduct research

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

18 November 2015

Mrs Lamese Bryczkowski (SN 212545096)
School of Applied Human Sciences
College of Humanities
Howard College Campus
UKZN
Email: mkdlam001@gmail.com

Dear Mrs Bryczkowski

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your postgraduate studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"A qualitative study of trainee boundary difficulties in Psychotherapy".

It is noted that you will be constituting your sample by conducting interviews with students registered for the Psychology Masters, Clinical and Counselling program on the Howard College Campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

MR SS MOKOENA
REGISTRAR

Office of the Registrar
Postal Address: Private Bag X54001, Durban, South Africa
Telephone: +27 (0) 31 260 8005/2206 **Facsimile:** +27 (0) 31 260 7824/2204 **Email:** registrar@ukzn.ac.za
Website: www.ukzn.ac.za

Appendix D

Full ethical approval

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

4 December 2015

Mrs Lamese Bryczkowski 212545096
School of Applied Human Sciences
Howard College Campus

Dear Mrs Bryczkowski

Protocol reference number: HSS/1301/015M
Project Title: A Qualitative Study of Trainee Boundary Difficulties in Psychotherapy

Full Approval – Expedited Application

In response to your application received on 3 September 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Supervisor: Prof Duncan James Cartwright
Academic Leader Research: Dr Jean Steyn
School Administrator: Ms Ayanda Ntuli

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